UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES

CAYUGA MEDICAL CENTER AT ITHACA, INC.,

Cases 03–CA–185233
and 03–CA–186047

1199 SEIU UNITED HEALTHCARE WORKERS EAST

Jessica L. Noto, Esq. and
Alicia E. Pender, Esq.
for the General Counsel
Raymond J. Pascucci, Esq. (Bond, Schoeneck & King, PLLC),
for the Respondent
Mimi C. Satter, Esq. (Satter Law Firm, PLLC),
for the Charging Party

DECISION

INTRODUCTION

KIMBERLY SORG-GRAVES, ADMINISTRATIVE LAW JUDGE. The charges in these cases follow on the heels of an unfair labor practice hearing conducted by administrative law judge David I. Goldman addressing allegations that Cayuga Medical Center at Ithaca, in New York, (CMC or Respondent) violated the National Labor Relations Act (Act) in response to a union organizing effort by its registered nurses (RNs). The events at issue in the instant case occurred after that hearing concluded but before ALJ Goldman issued his decision in the prior proceedings finding that Respondent violated the Act when it made threats, directives, and prohibitions on union activities, issued a disciplinary warning to one employee, and demoted, suspended, and adversely evaluated RN Ann Marshall. ALJ Goldman's decision was enforced by the Board in pertinent parts. See *Cayuga Medical Center at Ithaca, Inc.*, 365 NLRB No. 170 (2017) (affirming in pertinent parts *Cayuga Medical Center at Ithaca, Inc.*, JD-104-16, Ithaca, NY, 2016 WL 6440996 (Oct. 28, 2016)).[1]

In the instant cases, the General Counsel of the Board alleges that CMC continued its retaliatory conduct when it suspended and discharged Marshall and fellow RN Loran Lamb and prohibited the posting of union literature.[2] For the reasons discussed below, I find that CMC unlawfully suspended and subsequently discharged Marshall and Lamb in an effort to rid itself of the union organizing drive

[1] I took judicial notice of the transcripts, exhibits, and administrative decision in this prior case and refer to it herein as JD-104-16. The parties were directed to specifically cite the page number of any reference to the transcripts, exhibits, or decision in JD-104-16 in their briefs. (Tr. 25.)

[2] During the testimony of registered nurse Nathan Newman, I granted General Counsel's motion to amend the complaint to include an allegation that Respondent failed to inform employee witnesses, whom its counsel interviewed in preparation for the hearing, about the safeguard warnings required under *Johnnie's Poultry Co.*, 146 NLRB 770 (1964). (Tr. 2514.) Respondent denied the allegation. As discussed more fully below, I find insufficient evidence of a violation and dismiss this allegation.

perpetuated by Marshall. CMC's claim that Marshall's and Lamb's failure to follow established procedures while performing and documenting a blood transfusion was so egregious as to necessitate their discharges is a ruse for its real motivation of removing Marshall's vocal support for unionization. In deciding to suspend and later discharge Marshall and Lamb for the alleged violations of CMC policies, the administrators chose to ignore information it uncovered in its investigation that other nurses performed blood transfusions in the same manner, disregarded its practices of re-educating staff in such circumstances, and deviated from providing its employees with progressive discipline. CMC also violated the Act by removing union literature from bulletin boards while allowing other non-CMC sponsored literature to be posted on the bulletin boards.

STATEMENT OF THE CASE

On September 29, and October 12, 2016, 1199 SEIU United Healthcare Workers East (Union or Charging Party) filed the unfair labor practice charges at issue. The charges were docketed by Region 03 of the Board as Cases 03-CA-185233 and 03-CA-186047, respectively. On November 22, 2016, the Union filed an amendment to charge 03-CA-185233. Based on an investigation into these charges, on November 29, 2016, the Board's General Counsel, by the Regional Director for Region 03 of the Board, issued a consolidated complaint and notice of hearing alleging that, by suspending and discharging Marshall and Lamb and by prohibiting employees from posting union literature around the facility while permitting employees to post other literature, Respondent violated Section 8(a)(3) and (1) of the Act. On December 13, 2016, Respondent filed an answer denying all alleged violations of the Act.[3]

I heard this matter on January 9-12, February 27-March 3, March 6-10, and April 3-4, 2017, in Ithaca, New York. I afforded all parties a full opportunity to appear, introduce evidence, examine and cross-examine witnesses, and argue orally on the record.[4] General Counsel, the Union, and Respondent filed post-trial briefs in support of their positions by May 26, 2017.

After carefully considering the entire record, including my observation of the demeanor of the witnesses, I find:

JURISDICTION

At all material times CMC has been an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act, and a health care institution within the meaning of Section 2(14) of the Act. At all material times, the Union has been a labor organization within the meaning of Section 2(5) of the Act. Based on the foregoing, I find that this dispute affects commerce and that the Board has jurisdiction of this case, pursuant to Section 10(a) of the Act. (GC Exh. 1(g) and (i).)[5]

[3] On December 22, the Regional Director of Region 03 issued an amendment to paragraph V of the consolidated complaint to allege supervisory and agent status which was admitted by Respondent in its answer to complaint amendment on January 5, 2017.

[4] All references to "hearing officer Schaefer" throughout the transcript are corrected to read "ALJ Sorg-Graves." On May 23, 2017, General Counsel submitted a motion to correct the record to remove R. Exhs. 61, 71, and 79, because I rejected them on the record. (Tr. 3580, 3582-3583.) Similarly, I rejected R. Exh. 46 on the record. (Tr. 2066-2067.) Accordingly, I grant General Counsel's motion to correct the record to exclude R. Exhs. 61, 71, and 79. Furthermore, I correct the record to exclude R. Exh. 46.

[5] Abbreviations used in this decision are as follows: "Tr." for the Transcript, "GC Exh." for the General Counsel's exhibits, "R. Exh." for Respondent's Exhibits, and "U. Exh." for the Union's Exhibits. Specific citations to the transcript and exhibits are included where appropriate to aid review, and are not necessarily exclusive or exhaustive.

UNFAIR LABOR PRACTICES

Below, I first set forth some background information that provides context to the environment in which the allegations are alleged to have occurred. Second, I address my finding that CMC violated Section 8(a)(1) of the Act by one of its supervisors/agents removing union literature posted on a CMC bulletin board. I also discuss CMC's hostility towards this and other union activity in which Marshall engaged.

Third, I review the extensive information necessary to evaluate the allegation that CMC violated the Act by suspending and discharging Marshall and Lamb. This includes a review of CMC's transfusion procedure and prohibition on falsifying medical records, the blood transfusion at issue, CMC's discipline model, CMC's investigation findings, CMC's refusal to acknowledge or further investigate its findings that Marshall's and Lamb's conduct in administering the blood was a common practice in ICU, and comparison discipline evidence. Then, I analyze why I find that the evidence supports a finding that CMC violated Section 8(a)(3) and (1) of the Act by suspending and discharging Marshall and Lamb.

Finally, I address my dismissal of the allegation that CMC violated Section 8(a)(1) of the Act by failing to inform an employee of the safeguards set forth in the Board's *Johnnie's Poultry Co.* decision.

A. Background

1. Brief description of CMC and the individuals involved

CMC is an acute care hospital with approximately 230 practicing physicians. CMC operates an emergency department (ED), intensive care unit (ICU), oncology unit, maternity and pediatrics units, surgical units, medical and telemetry units, rehabilitation center, mental health unit, and other departments. CMC employs approximately 400 RNs, including per diem and part-time nurses, and hundreds of other employees necessary to operate the hospital. As a result, CMC has an extensive managerial structure, including but not limited to the following managerial/supervisory personnel, who are supervisors and/or agents of CMC within the meaning of Section 2(11) and 2(13) of the Act:

--John Rudd, chief executive officer (CEO)
--John Collett, chief financial officer (CFO)
--Brian Forrest, vice president of human resources (VP of HR)
--John Turner, vice president of public relations (VP of PR)
--Debra Raupers, vice president of patient services, systems, chief nursing officer since 2015
--Linda Crumb, assistant vice president of patient services and acting director of ICU
--Karen Ames, chief patient safety officer and director of quality and patient safety
--Dr. Daniel Sudilovsky, chairman of the pathology laboratory medicine and director of the laboratories
--Kansas Underwood, director of medical palliative and telemetry units
--Jacqueline Barr, director of patient customer relations
--Shawn Newvine, director of ICU from 2003 until April 2015
--Barbara Goodwin, director of staff development
--Bernice Miller, director of medical rehabilitation and interim director for the mental health unit from November 2015 until February 2017
--Kristen Verrill, director of CMC's center for healthy living, an outpatient rehabilitation center
--Terri Maccheyne, director of maternal-child health, maternity and pediatrics unit
--Crystal Chaffin, manager of 4-north medical unit
--Anna Murray-Bartels, quality and patient safety officer working under Karen Ames
--Brenda Twomey, clinical liability risk manager working under Karen Ames

The bulk of the remaining individuals discussed below work as RNs, but each individual's job title/position is noted.

2. Prior ALJ decision

Based upon various charges filed by the Union between July 2015 and January 2016, ALJ Goldman conducted a hearing on various dates during the spring of 2016. The events at issue in this case occurred in September and early October 2016, before ALJ Goldman's decision issued on October 28, 2016, which the Board affirmed in pertinent parts on December 16, 2017.[6] *Cayuga Medical Center,* supra at slip op. 1. I find that it is unnecessary to rely upon ALJ Goldman's resolution of disputed facts in that decision in order to arrive at a decision in this case, but I take notice of some of the uncontroverted evidence presented in that proceeding and the Board's affirmation of the finding that CMC harbored animus towards Marshall's union activities.

The union organizing drive was initiated in late 2014 or early 2015 during a period of staffing shortages at CMC, especially in the ICU where Marshall and Lamb work. Marshall openly supported the Union by distributing union literature and discussing the Union with fellow employees in the cafeteria and other places within CMC. Upon learning of the organizing drive, CMC launched an antiunion campaign by issuing emails to and conducting one-on-one meetings with its nursing staff expressing its objections to unionization. Marshall testified during the 2016 hearing about her activities on behalf of the Union and with regard to a demotion, suspension, and poor performance evaluation that she had received after initiating her protected activities. Management officials admitted to being aware of several of Marshall's activities on behalf of the Union. Accordingly, I find that Respondent was keenly aware of Marshall's protected activity.

ALJ Goldman found, and the Board affirmed, that Marshall had not received any disciplinary action and had only received excellent performance evaluations prior to engaging in protected activity and that CMC demoted, suspended, and adversely evaluated Marshall because of animus against her union and other protected activity.[7] Id. However, it is unnecessary for me to rely solely upon the findings of animus in that decision. As discussed below, I find that the record in the instant case establishes CMC's animus towards union activity in general and specifically against Marshall's engagement in that activity. Similarly, it is not necessary for me to rely upon the findings in the prior decision that CMC had disparately demoted, suspended, and evaluated Marshall, because CMC contends that Marshall's discharge was based solely upon her failure to follow established safety procedures in administering a blood transfusion on September 11, 2016.

3. CMC's hostility towards Marshall's union activity, and Lamb's union activity

After testifying in the prior proceedings about various topics including her union activity, Marshall continued to engage in union activity and was recognized by CMC as the lead union organizer. She continued to attend union meetings, post union literature on bulletin boards at CMC, and utilized social media to spread her message in support of the Union. Lamb also supported the Union, but her activity was not as readily apparent as Marshall's activity.

CMC continued to be aware of Marshall's protected union and other concerted activities. For example, in August 16, Marshall sent an email to various CMC staff, including RNs, and CMC's Board of Directors,

[6] All dates herein refer to 2016 unless otherwise noted.

[7] Lamb had also received only excellent performance evaluations and had no prior disciplinary history at the time of her discharge. (Tr. 1566; GC Exh. 42.)

with the subject line of benefits. The email compared CMC's pension with the Union's pension, discussed the expense of CMC's antiunion campaign, and mentioned that CMC continued to lay-off employees while using contracted RNs. The email included a copy of the hospital's 2014 tax return. This email was forwarded by another RN to CMC's chief patient safety officer and director of quality and patient safety, Karen Ames, on August 22 with a one word comment, "Discouraging." (GC Exh. 72.)

In August, VP of HR Brian Forrest set forth a plan to continue CMC's antiunion informational campaign with a list of topics to cover, including addressing what it perceived as the "Union or Ann Marshall Focus—I will take the place down—Bullying any who disagree—Maligning Organization (eg: saying score was a 2—not a 3 [on a hospital rating scale])." The next in these series of flyers was a "Did you know/You're not alone" flyer listing what CMC perceives as being the negative effects and costs of unionization for employees.

Either by direct monitoring or by receiving information from other employees, CMC management was aware of Marshall's continued union activity, and specifically, statements that she made about the union organizing campaign and related matters on social media. For example, a September 29 email concerning preparations for a letter in regard to the planned discharges of Marshall and Lamb that was ultimately distributed on October 6 to all of CMC's employees, physicians, and volunteers, CMC's VP of public relations John Turner tells CEO John Rudd: If Anne Marshall launches and things go public before the BOD [Board of Director] meeting, I think we should send them the attached internal communication with a slight revision. . . .Things have been quiet on the social media end." (GC Exh. 19.) Turner claimed that he was preparing for Marshall's discharge early because in relation to the unfair labor practice charges in 2015 Marshall reached out to various forms of media "spreading misinformation" and leaving him in "reactive mode." (Tr. 900.) Turner stated that Marshall seems to be the one leading it, referring to what he regarded as "misinformation." Turner noted that Marshall had been on a radio program with an SEIU representative as well. (Tr. 902-903.) Turner stated that within an hour of submitting her resignation, Marshall went public by posting information about her discharge/forced resignation on Facebook. (Tr. 887.) CMC was still monitoring Marshall's social media posts at the time of the hearing and Respondent questioned her about links she had posted shortly before she testified. (Tr. 1389-1392; R. Exh. 72.)

On October 6, CMC's CFO John Collett sent an email forwarding the October 6 letter that was sent to all CMC staff, physicians, and volunteers about the discharges of Lamb and Marshall to an undetermined individual outside of the CMC email network. Collett commented: "One of the nurses was the lead union organizer. We parted company with the 2-RN's[.]" Thus, I find that CMC was not only aware of Marshall's union activity addressed in the prior hearing but of her ongoing protected activity, and that CMC harbored significant hostility towards that activity.

Lamb was less engaged in union activities than Marshall, and CMC denies awareness of her protected activity. (Tr. 3341.) Lamb participated in the union organizing drive by signing a card, attending meetings, and on at least one occasion by sitting at the table in the cafeteria with Marshall while Marshall distributed union literature. (Tr. 1526.)

Lamb wore a button that she got from Marshall with a picture of "Rosie the Riveter" with wording that states: "We can do it," "Rosie the Riveter," and "www.rosieriveter.com." She wore it on her scrubs during about two-thirds of her shifts. Lamb wore the button to a meeting in late August or early September with assistant vice president of patient services and acting director of ICU Linda Crumb and

Ames in which they were attempting to track down information about a patient who had died over a year earlier. (Tr. 1531.) Neither Crumb nor Ames commented on the button.[8]

In late spring or early summer of 2015, Lamb was approached by the new interim director in ICU, Joel Brown, who requested that she meet with him. In the one-on-one meeting Brown told Lamb that RNs were trying to get other RNs to sign union cards and stated CMC's negative views on unionization. Lamb told Brown that she had been approached, but the RN had not acted in a bullying fashion and that she was capable of making up her own mind. The meeting ended shortly after that response. (Tr. 1527-1528.) The interviewers in these meetings reported their impressions of whether individuals were pro-union or antiunion, but the record is silent as to how Lamb was perceived. (JD-104-16.)

Although Rosie-the-Riveter is a well-known symbol of labor movements within circles familiar with organizing campaigns, I find it impossible to definitively impute knowledge of Lamb's union activities on CMC based upon her wearing the button and her conversation with Brown. The record contains no evidence that the Rosie-the-Riveter button had been used as a widespread symbol of the union movement at CMC and Lamb's comments to Brown did not definitively establish that she supported the union. I find no evidence of CMC exhibiting animosity specifically towards Lamb due to such activity, but, as discussed above, there is an abundance of evidence that CMC held animosity towards unionization.

B. Respondent violated Section 8(a)(1) of the Act by prohibiting employees from posting union literature around the facility while permitting employees to post other literature.

Marshall's continued support of the Union included posting union literature on bulletin boards at CMC. In about July, CMC director of patient and customer relations Jacqueline Barr removed a union flyer from a bulletin board near a third floor time clock. Barr recalled that while she was removing a union flyer from a cloth covered bulletin board near the third floor time clock in the hallway by the elevator, Marshall approached and asked why she took it down. Barr told Marshall that she was not done yet and that she was going to remove all the postings not sponsored by CMC. Barr testified that she regularly removed all postings from CMC-regulated bulletin boards such as Jehovah Witness cards and other personal flyers. Marshall told Barr that she should not be touching the union posting. Marshall then looked at Barr's name on her badge. Barr said that she should make sure she spelled it right. Marshall replied that she knew who she was and complained that someone kept taking the postings down. Barr then directed her to the general bulletin board across from the cafeteria and stated that anyone could post on that bulletin board. (Tr. 2878-2880.)

Marshall recalled that the posting was not on the fabric covered bulletin board but on a traditional tan cork bulletin board by a different time clock in another hallway on the third floor. Marshall claimed that Barr had only removed the union flyer announcing an upcoming union meeting without removing other non-CMC sponsored flyers. Within a couple of weeks of her encounter with Barr, Marshall took a picture of the same bulletin board on which an antiunion flyer and other non-CMC sponsored items such as a Jehovah Witness card were posted.

Barr claimed that the fabric-covered bulletin boards by time clocks are restricted to CMC-sponsored postings and that to her knowledge only the general bulletin board by the cafeteria is where anyone could post flyers. (Tr. 2881-2882; 2884-2885.) Barr was not able to cite a CMC policy to back her assertion that non-CMC sponsored postings were not allowed on certain bulletin boards. Instead she relied upon her personal belief to support her daily purging of bulletin boards. (Tr. 2897.) I find Barr's reasoning for

[8] The only individual to comment on the button that Lamb identified as a supervisor was Nate [last name not in record] who works in the cafeteria, but I find the record is inconclusive as to his supervisory status. (Tr. 1527, 1529-1530.)

her actions contrived to conceal her real action which was to remove union literature from bulletin boards as Marshall asserts she did.

I find that Barr was not privileged to remove the union flyer. Other than Barr's unsubstantiated vague recollection of some restriction on bulletin boards, CMC presented no evidence of such a policy. Furthermore, in the prior unfair labor practice proceeding, CMC did not contest that employees have a right to post nonhospital related material on the bulletin boards throughout the facility, but, consistent with to Barr's actions in this case, that it had a right to remove the union postings. (JD-104-16.)

As the Board affirmed ALJ Goldman's findings with regards to the prohibiting of posting and removal/confiscating of union literature from bulletin boards throughout the facility, I find based on clear Board precedent that under these circumstances employees are privileged to post union flyers and management officials are not privileged to remove them. *Cayuga Medical Center*, supra at slip op. 2; *St. Margaret Mercy Healthcare Centers*, 350 NLRB 203, 203 (2007); *NLRB v. Baptist Hospital, Inc.*, 442 U.S. 773, at 779-791 (1979);*Wal-Mart Stores*, 340 NLRB 703, 709 (2003); *Container Corp. of America*, 244 NLRB 318, 318 fn. 2 (1979), enfd. 649 F.2d 1213 (6th Cir. 1981). Accordingly, I find that Barr's removal of union literature from a bulletin board violated Section 8(a)(1) of the Act.

C. The suspensions and discharges of Marshall and Lamb

Because CMC contends that it suspended and discharged Marshall and Lamb for not complying with the transfusion policy and for falsely documenting that they had, I first evaluate those policies and the incident for which Marshall and Lamb were suspended and discharged. After learning of the incident, CMC embarked on an unprecedented investigation of the matter. I address the numerous steps of the investigation and management's behind the scene communications about the matter in as close to chronological order as coherency allows. Then, I conduct a review of the prior discipline that CMC contends supports the suspensions and discharges of Marshall and Lamb. It is from this complex factual evaluation that I derive the conclusions made below.

1. Blood transfusion policy and the blood transfusion card

CMC contends that it discharged Marshall and Lamb because they failed to comply with procedures contained in CMC's blood transfusion policy and then falsified medical records to reflect that they had followed the required procedure. Thus, it is first necessary to understand the blood transfusion policy, its related blood transfusion card, and CMC's policy with regard to falsifying medical records.

CMC provides acute care hospital services, and therefore, must maintain a blood bank which is housed as a separate section of its laboratory. (Tr. 1839.) The record is replete with testimony that transfusing incompatible blood to a patient will cause an irreversible allergic reaction which results in death. Failure to properly refrigerate, handle, or administer blood products can render them unfit to be transfused, which can also cause significant harm or possible death to patients if used. Even if all precautions are taken, some patients still have unexpected reactions to blood transfusions that can result in a range of reactions from less serious symptoms to death. Therefore, patient's vital signs are specifically monitored through the first 15 minutes of the transfusion. (Tr. 1849.) To prevent such an occurrence, acute care facilities must maintain policies that comply with state regulations covering the storage, handling, and transfusion of blood products. (Tr. 1839-1840.)

CMC maintains hundreds of policies setting forth the proper procedures for tasks related to patient care. (Tr. 1581, 2098-2099.) These procedures are maintained and accessed on an intranet cite. CMC requires its personnel to perform regular training through a computer system called HealthStream to stay familiar

with these procedures. The RNs are required to complete numerous hours of HealthStream training during regular work shifts each year. (Tr. 93; R. Exhs. 50, 64.) CMC typically schedules policies for high-risk procedures for periodic review with additional training if substantial changes are made to the procedures. The blood transfusion policy was only reviewed in HealthStream when changes were made to it. (GC Exh. 74.) Because the policies are constantly subject to change, CMC directs its staff to access them online when needed instead of printing and maintaining a copy. (Tr. 2105.)

Until 2012 CMC's blood product transfusion policy required, in addition to other procedures, that two RNs verify identifiers related to the unit of blood and the patient receiving the blood at the patient's bedside before the transfusion was implemented. This 2-RN check at the patient's bedside is the accepted practice in the industry to prevent accidental transfusion of an incompatible blood product to a patient. (Tr. 1584.)

Using this 2-RN bedside check in 2012, an incident occurred where the wrong unit of blood was taken into a patient's room prepared and spiked for transfusion before the RNs involved discovered the error.[9] Because of this "near miss" incident, CMC conducted an extensive review of its transfusion policy. (Tr. 2627.) The process of reviewing the policy took several months. The 7th version of the revised transfusion policy was issued on November 25, 2013. (Tr. 2679-2680.) CMC contends that the 7th version of the transfusion policy was still in effect on September 11, 2016, the date of the incident in question. Although General Counsel questioned the validity of this assertion, I find no credible evidence of any substantial changes to the policy in that timeframe. Therefore, I find that the 7th version of the transfusion policy was in effect on September 11. (GC Exh 3.)

The transfusion policy sets forth procedures for obtaining patient consent and the various aspects of procuring, handling, transfusing, and discarding of blood products along with documenting these processes and the patient's vital signs and reactions throughout the process. There are several additional steps in the procedure that a RN must take before and after the transfusion process. CMC contends that Marshall and Lamb were discharged for failing to properly perform and document the following steps of the transfusion procedure:[10]

> 12. A two-tier verification should be implemented on inpatient floors:
> A) Before taking blood into the patient room, the two nurses must verify the blood against the order and chart for correct patient name, blood type, type of blood product. No product should enter the patient room until it is verified.
> B) Inside the room, verification must occur matching the blood to the patient with two identifiers (name, date of birth [DOB]); verbally and against the patient wrist band.
> C) The blood must not be hung before the verification has occurred. If the nurse is interrupted for something more pressing, the incoming nurse will need to re-verify that the product is correct before transfusing.
> 13. Perform the 2-RN bedside checklist:
> A) Verify the provider's order.
> B) Verify that the consent has been signed by the patient (or appropriate representative).

[9] This "near miss" incident is discussed in more detail below.

[10] Respondent repeatedly questioned witnesses about Lippincott's Nursing Procedures Manual as being the national standard in nursing. (R. Exh. 47.) Although available at the hospital, none of the RNs testified that they refer to the manual in their practice with any regularity. CMC's transfusion policy is similar to the Manual's policy and contains the same core elements to be verified by the administering RNs at the patient's bedside. (Id. at pg. 4.) I find that item 13 of CMC's transfusion policy is consistent with the procedure contained in the Manual and is consistent with what RNs testified they learned in nursing school and from prior employers. CMC's transfusion policy is unique in its requirement in item 12 that 2 RNs complete these same verifications outside the room with the patient's chart and that on its face item 12, specifically item 12B, is not consistent with item 13.

C) Check the blood bag number, expiration date, blood type and Rh.
D) Two RNs must identify the patient at the bedside by asking the patient for his or her name and date of birth. This is compared to the patient's armband and blood Transfusion Card.
E) Transfusion card will be completed in its entirety by two RNs/GNs and upon completion returned immediately to the lab,
F) *Wear gloves when handling blood bag.*

(GC Exh. 3.) Although the testimony concerning the process of updating and publishing changes to the transfusion policy is confusing, the record reflects that the policy was updated to version 8 on September 12, 2016, one day after the incident for which Lamb and Marshall were discharged. (GC Exh. 60.) Those changes do not appear to be directly related to the incident. After the start of the hearing, CMC updated the transfusion policy to version 9 on January 20, 2017, in a manner that specifically relates to its contentions in this matter. CMC changed the language quoted above in paragraph 12 from stating that a, "A 2-tier verification should be implemented on inpatient floors" to stating that, "A 2-tier verification will be implemented."[11]

To document the performance of a blood transfusion, RNs are required to complete a blood transfusion card (transfusion card). (GC Exh. 2; R. Exh. 62, 66, 68, 69, 70, 73.) After a unit of blood is ordered, the lab technician types on the top of a 3-ply stock transfusion card identifying information about the blood product and the intended recipient such as donor's blood type, donor identification number, unit identification number, expiration date, patient's name, patient's account number, patient's blood type, and ordering doctor's name. The lab technician issues the unit of blood to a courier, and they document on the transfusion card the date and time it was issued, to which department in the hospital (also referred to as a unit) it was issued, and that the unit of blood appeared normal and was not outdated.[12] (Id., Tr. 67-69.) The unit of blood is delivered to the requesting RN. Once the RN responsible for the patient (primary RN) has completed necessary pre-transfusion procedures such as doctor ordered pre-medications, preparation of intravenous lines, etc., the primary RN solicits the participation of a second RN (secondary RN) to perform the procedures in paragraphs 12 and 13 above and document them in the middle portion of the transfusion card as shown below.[13]

Transfusion Staff: **Transfusion Checklist**

All items below are to be verified by two Practitioners and initials placed in appropriate box.

Physician Order Verified		Informed Consent has been obtained	

Below information must be verified at Patient bedside

Patient Name, DOB on bracelet agrees with those on tag.		Unit type and Rh donor # on this form are the same as on container.	
Unit is not outdated.		Date Started: 2/18/14	Time Started: 1040

I have carefully completed the checklist, APPLIED GLOVES, and started the transfusion.
Signed: Started By:

[11] Paragraph 12 of the transfusion policy was renumbered as paragraph 13 in version 8 due to changes made to other paragraphs, and continued to be listed as paragraph 13 in version 9. (GC Exh. 60.)
[12] The courier can be the requesting RN, another RN, or another otherwise qualified hospital employee. A courier can receive the blood product for only one patient at a time. (GC Exhs. 3 and 60.)
[13] For some procedures such as medication administration, the RNs scan a barcode for the medication and the barcode on the patient's identification bracelet before administering the medication, but CMC does not have a barcode reading system for blood products. There is no barcode on the units of blood for the RNs to scan. (Tr. 76, 1861-1862; GC Exh. 68.)

(R. Exh. 66, p. 2.)[14] The transfusion card also requires the primary RN to record the patient's vital signs at the start of the transfusion and 15 minutes later, the date and time the transfusion ended, the amount transfused, whether an adverse reaction occurred, and sign as the RN who ended the transfusion.[15]

As is discussed more fully below, some of the RNs' variance in understanding the transfusion policy was likely spurred by the lack of consistency between steps 12 and 13 of the transfusion policy and the corresponding sections of the transfusion card. Step 12 requires that before blood is taken into the patient room, "two nurses must verify the blood against the order and chart for correct patient name, blood type, and type of blood product," but the transfusion card only appears to require the nurses to confirm that the "physician order [was] verified" and "informed consent ha[d] been obtained." Step 12B only requires that the patient's name and date-of-birth be verified verbally and against the patient wrist band. Step 13 is inconsistent with Step 12B. Step 13 requires that the 2 RNs verify the following at the bedside: the doctor's order and the patient's consent are in the patient's file, and check the blood bag number, expiration date, blood type and Rh, and the patient's name and birthdate by asking the patient and comparing the patient's armband to the blood transfusion card. However, the transfusion card only requires verification of the expiration date, blood type and RH, and comparing the patient's armband to the blood transfusion card. (Tr. 259-261.)

Step 13 goes on to state that the "transfusion card will be completed in its entirety by two RNs/GNs and upon completion returned immediately to the lab." But the sections of the transfusion card following the reproduced portion above are clearly intended to be completed by the primary RN alone. The transfusion card is returned to the lab after the completion of the transfusion, as much as 4 hours after the secondary nurse assisted in checking the blood and documenting that check on the transfusion card.

CMC contends that in addition to violating the transfusion policy by failing to perform certain steps of the procedure, Marshall and Lamb falsified medical records by completing the transfusion card without having performed the 2-RN bedside check. CMC's policy concerning falsification of data states: "Falsification of data is not allowed. If determined that data is falsified the employee responsible will receive disciplinary action." (R. Exh. 44(a).) A provision of CMC's electronic library states, "No information in the medical record may be falsified. If information is found to be falsified disciplinary action will result." (Tr. 2092; R. Exh. 44b, pg. 7.) CMC distinguishes between unintentional errors or mistakes made due to lack of training/knowledge and intentional false documentation. (Tr. 1859.) As discussed further below, I find that CMC is tolerant of employees committing a significant amount of what can only reasonably be determined to be intentional inaccurate documentation before discipline results.

2. The blood transfusion incident for which Marshall and Lamb were allegedly discharged

The incident at issue occurred on September 11. The staffing level in ICU was typical for that unit. Each of the 4 RNs on duty was assigned two patients, which is the maximum ratio of patients-to-RN for the ICU. One patient was on mechanical ventilation and in restraints and another patient required constant monitoring by a staff member. One patient was transferred out of ICU and another transferred into ICU. The on-call nurse had not been called in, charge nurse Scott Goldsmith was not assigned a patient, and

[14] The transfusion card completed by RN Marshall and RN Lamb for the transfusion at issue was not used as the example because of its poor copy quality. (See GC Exh. 2.)

[15] Because a transfusion takes up to 4 hours, it is not uncommon for a change of shift to occur and for the incoming primary RN for the patient to end a transfusion started by an RN on the earlier shift.

there was no ward clerk on duty.[16] (Tr. 1539-1540, 1616-1617; GC Exh. 39.) Marshall was assigned patient SF, who because of her condition had low immunity and required blood transfusions. There is no record evidence concerning the requirements of Marshall's other patient. Lamb was caring for a patient with a serious leg infection that continued to worsen during her shift, causing him to be put on life support after her shift ended. Her other patient, who did not require ICU care on September 11, but was likely to need ICU care after a scheduled cardiac catheterization, was not transferred to a different unit. (Tr. 1543, 1620-1621.) Marshall, Lamb, and Goldsmith all described the shift as busy, but the on-call nurse was not called into work.

Marshall received a physician's order for a blood transfusion for patient SF. Marshall followed the proper transfusion policy steps to have the laboratory prepare the unit of blood and a courier retrieved it for her. Marshall also properly administered pre-transfusion medications to patient SF. Although not required by CMC protocols, patient SF had asked that neutropenic precautions, use of mask and gloves, be taken by everyone who entered her room. Although patient SF and her sister Star York complained that some CMC staff failed to follow neutropenic precautions, there were no allegations that Marshall did not follow these procedures.

According to Marshall, upon receiving the blood she asked charge nurse Goldsmith to check the blood with her, but he directed her to check it with Lamb.[17] Marshall took the chart and blood to Lamb at the nurse's desk to check it. (Tr. 1224-1234.) Charge RN Goldsmith was about 6 feet away looking at the white board that lists the assignments for the unit. Marshall and Lamb verified all the required items at the desk, and they both initialed and signed all of the entries on the transfusion card for patient SF. (Tr. 1235; GC Exh. 2.) Marshall and Lamb used a sticker on the file that contained the same information as patient SF's identification bracelet, to verify the patient's name, date-of-birth, and account number. (Tr. 1235-1236.) I find no evidence contradicting Marshall's and Lamb's contentions that they performed a thorough check of all of the items at the desk.

After completing the check at the desk, Marshall took the blood to the patient's room without Lamb. (Tr. 1238.) Lamb did not accompany Marshall into the room to perform a second check of the blood at the bedside, as it had become her general practice not to do so unless some circumstance caused her to be more cautious. Lamb typically only went to the patient's room to check the patient's identification bracelet if she was working with a new or unfamiliar nurse, or when patients with similar names were in the ICU.[18] (Tr. 1548.) Lamb stated that she had developed this practice despite the policy's requirement

[16] A ward clerk takes care of necessary secretarial duties such as answering the phone and copying records. When no ward clerk is on duty, these tasks fall to the RNs. (Tr. 1543, 1620-1621.)

[17] I credit Marshall's testimony that she asked charge nurse Goldsmith to assist her with verifying the blood; Goldsmith was unable to refute her testimony. (Tr. 2936.) I find much of Goldsmith's testimony unreliable as he repeatedly stated that he was unable to remember with accuracy the conversations he had with Marshall and Lamb directly after the incident, why he did not file the incident report in this matter until September 13, how many times he spoke to Ames about this incident or what he said to her in these conversations. (Tr. 2942, 2949, 2968-2969, 2971.) His vague testimony and general lack of recall for these specific situations, especially after it was apparent that management was taking special interest in this situation weighs against the reliability of his testimony. Furthermore, Goldsmith was extremely nervous while testifying and moved about in his seat so much that he knocked the microphone off the witness stand once, and almost did so again, even after it was repositioned away from him. (Tr. 3018.) Since Goldsmith was called by Respondent and testified that he reviewed his testimony with Respondent's counsel before being called to testify, I found Goldsmith's uneasiness paradoxical with the expected demeanor of an employee who was honestly testifying on his employer's behalf. Thus, to the extent his testimony is contradicted by other witnesses, it is not credited.

[18] I credit Lamb's testimony. She gave straight forward answers to questions posed by all parties. Despite how upsetting she found the whole situation she maintained her decorum and gave specific answers to the questions

of a bedside check because of how busy they regularly were in the ICU and out of concerns for other patients. Lamb expressed no concerns that Marshall, an experienced nurse with whom she was familiar, would administer the blood to the correct patient under the circumstances. (Tr. 1546.)

Marshall practiced neutropenic precautions (donned mask and gloves) when she entered patient SF's room. After entering the room with the blood, she primed all the tubing and set the blood up to be transfused. Marshall insists that she asked patient SF her name and date-of-birth and looked at her wrist band before starting the transfusion. (Tr. 1238.) Marshall performed the necessary tasks to initiate the transfusion. As she was initiating the transfusion patient SF asked her if she had checked the blood, Marshall testified that she responded, "I have absolutely checked the blood."-- "I have checked it out at the nurse's station with another nurse." (Tr. 1229.) Marshall testified that she believed she had addressed patient SF's concern because she did not bring the matter up to her again. Marshall stated that she started the transfusion and made sure it was running and there were no issues before taking the transfusion card off the unit of blood and taking it to the nurse's station. Marshall wrote on the transfusion card that she started the transfusion at 12:50 p.m. (GC Exh. 2.)

Marshall testified, "I don't feel that when I did it, I was purposefully skipping something." And I did check all of those things [listed on the transfusion card] and I had no doubt at the time that every identifier lined up and the right person was getting the right blood." (Tr. 1270.) Marshall stated that she did everything that she initialed on the transfusion card including the bedside patient identifier checks. I credit Marshall's testimony that she verified patient SF's name and date-of-birth before starting the transfusion. As is discussed below, York was unable to refute this testimony and admitted that she recalled Marshall doing so when she administered other treatments to patient SF. I find nothing in the statements made by patient SF or her sister that clarify that Marshall did not individually verify patient SF's identity. What patient SF's statement raises concern about was the lack of a more involved 2-RN protocol occurring at the bedside. I also find, as is discussed more below, that management, at best assumed that patient SF's statement indicated this and never specifically clarified with patient SF or her sister that Marshall had not individually verified patient SF's identity. Finally, the record contains no evidence that Marshall had ever received any type of warning or discipline for failure to identify and treat the correct patient. Therefore, I credit Marshall's testimony that she individually verified patient SF's identity consistent with her practice.

Marshall testified that when patient SF questioned her about checking the blood at the bedside, she did not recall that they policy required her to do so and that she only vaguely recalled that requirement later. (Tr. 1304-1306.) Based upon the testimony of other RNs discussed below, Marshall's testimony, and the statements attributed to Marshall by patient SF and her sister, I credit Marshall's testimony in this regard at least to the extent that she did not understand that she was required to perform the verification in that manner, as the way she performed the check had become a routine and open practice in ICU.[19]

York, a registered nurse in Maine who has worked full-time in a primary care unit caring for patients recovering from cardiac surgeries where she frequently performs blood transfusions, was present in the

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posed to her and readily clarified if she misstated something. Lamb presented with a passive demeanor. She is averse to making anyone upset with her. To lie while under oath or to her employer is not within her demeanor.

[19] Marshall presents as a frank, outspoken person who is willing to state her opinion and defend herself regardless of with whom she is interacting. This strong will is evident in her actions on behalf of the Union and in her failure to return calls to management while she was on vacation. Considering the actions that CMC has taken in response to her protected activity and the scrutiny she has been under, it is not surprising that Marshall has become defensive in her comments to management. I do not find that her attempts to defend herself and explain her actions as a reason to doubt her veracity, especially here where the record as a whole supports her testimony as to the pertinent issues. Therefore, I credit Marshall's testimony to the extent it is relied upon herein.

room when the transfusion at issue occurred and testified at the hearing. (Tr. 423-426.) York stated, "A nurse came in with the blood, spiked it, hung it, attached it…" (Tr. 443.) Interestingly, despite all of the testimony about how a bedside check with 2 nurses is the national standard, York testified that at this point in the transfusion process, "No red flags that had gone up in my mind." (Tr. 451.) Patient SF spoke up and asked, "what about the protocol at which the nurse responded, we did that at the desk…. " "My sister pushed on a little bit further and said, but it's never been done that way, there's always been two nurse[s] who came in and checked my bracelet and the nurse responded, oh, that must have been a new nurse." (Tr. 444, 457-458.) York could not recall whether or not Marshall asked patient SF her name and date-of-birth or checked her identification bracelet before initiating the blood transfusion but does recall that Marshall did do that each time when she administered medications to patient SF earlier in the day. (Tr. 488.)

According to York's testimony, it was not her training as a nurse that caused her concern over this incident but the look on her sister's face. (Tr. 444.) York testified that her sister was alert and oriented, but she was critically ill and not functioning at her normal capacity apparently caused by fear of the very real possibility that she would not survive this illness. (Tr. 519.) York later shared on a phone conversation with CMC VP of public relations John Turner that at the time of this incident her "sister was in a very scary place." York went on to share with Turner personal information about patient SF's state-of-mind about which she was not willing and was not required by the questions of the parties to testify. (Tr. 457-458.) York stated that she was upset by the lack of precautions taken by CMC staff for her sister, "I was pissed—other things in addition to a shoddy blood transfusion which was, you know, very likely something that could have led to her death." (Tr. 513, 514.) Based upon the notes taken by Rudd from this conversation, most of her concerns revolved around the lack of neutropenic precautions taken to prevent patient SF from contracting an infection which she had little immunity to defend against. (GC Exh. 18.) When asked at hearing what she felt was shoddy about the blood transfusion, York stated that Marshall had been disrespectful to her sister's question about the protocol. Despite her other complaints, York was never notified that any of her concerns other than Marshall's conduct was addressed by CMC. (Tr. 498-499, 503-505.)

The most reliable evidence of patient SF's recollection of the blood transfusion is the statement that she emailed to Ames on September 19. The email states:

> In July I started needing to have blood transfusions. From day one the nurses talked me through the protocol they would be following whenever they administers a blood product for me. Call for blood, wait. Get Tylenol and Benadryl. Blood arrives, 2 nurses are in the room with the blood. They scan my name band, they ask me my name and birthdate. They read my name and number off my wrist and compare it to the paperwork. They then read the numbers on the blood bag and compare it to the paperwork numbers, if everything matches, then they start the blood.
>
> Unfortunately I ended up in the hospital on September 5th. All my blood numbers were very low and I had an infection somewhere. In the next few days numerous blood products were hung and the protocol was followed. On September 11th it was determined that I would need a bag of blood. Nurse calls, we wait. My sister and aunt were in the room. The nurse (Anne) comes in hangs the bag and starts the blood. I looked at her and said "What about the protocol?" And she said "Oh, we did that at the desk."--and left the room. My sister, who is an RN in the state of Maine, ran over to the blood to check the numbers. I said "This isn't how it's ever been done." The numbers checked, so I relaxed, but when Scott [Goldsmith] came into the room (I think he was charge nurse for the day) I voiced my major concerns to him. All previous nurses had made me aware of the protocol and led me through it--this nurse did none, Scott told me

> he would speak to the nurse, and let me know after he did. I need the hospital to be aware of this breach of protocol and seriousness I felt being vulnerable in my bed.

(R. Exh. 6.)

As discussed above, patient SF's complaint was that two RNs had not performed the protocol of checking her wristband and unit of blood reading off the identifying numbers. No evidence directly contradicts Marshall's claim of individually checking SF's identity. Respondent was aware that it lacked evidence to refute Marshall's claim that she had individually verified patient SF's name and date-of-birth when in the room. This is evident in VP of HR Brian Forrest's October 14 email telling Ames, "If the opportunity arises in a visit with the sister to see if she would provide a statement that would include a validation that Anne did not check her sister's wristband that could be helpful to us as Anne's latest has been saying that they are lying and the more proof we have the less she has credibility." (R. Exh. 78.)

When Marshall left the room York went over and checked information on the blood bag to her sister's identification bracelet. Crediting Marshall that she took the transfusion card to the nurse's station as was her practice, and based upon York's testimony she apparently compared the blood type information on the bag of blood to patient SF's identification bracelet and it appeared right to her. York was unable to clearly describe what information she used to assure her sister that she was receiving the correct blood. As discussed below, York was more disturbed by Marshall's failure to calm patient SF than any genuine concerned that Marshall may be transfusing the incorrect blood.

The record is unclear as to the timing of the following events. At some point shortly after the transfusion had been started, patient SF asked charge nurse Goldsmith, who was passing by her room, to come into her room. According to Goldsmith, patient SF told him that her identification had not been check before the blood was hung. York stated that patient SF told Goldsmith that Marshall had come and hung the blood without another nurse being there to follow what patient SF understood the protocol to be, and asked him to check the blood. (Tr. 444-446.) It is unclear as to what information that Goldsmith checked while he was in the room, but he too verified that the information was correct and at some point reviewed the transfusion card to make sure it was complete. (Tr. 444-446.)

Goldsmith testified that he went straight from the patient's room to speak with Marshall then directly thereafter to speak with Lamb. (Tr. 2940.) Goldsmith said that he spoke to Marshall at one nurse's desk and only had to turn and take five steps to speak with Lamb. Marshall testified that he asked her to go to the copy room for this discussion. (Tr. 1239.) Neither Marshall nor Lamb testified that they saw or heard Goldsmith speaking to the other which seems unlikely if the conversations took place only 5 steps away from each other. Then Goldsmith testified to specific dialog between him and Marshall. "I said, 'Did you check her ID at the bedside?' She was like, 'No, we checked it out here at the desk.' I said, 'Well, where are we supposed to check the blood?' And she says, 'At the bedside.' And I said, 'Is there a reason why you didn't?' And she didn't really give me an answer. And I said is this -- are you -- actually, I'm not sure what I said after that. Basically I just said that we need to do it at the bedside. And she said that she would." (Tr. 2940.)

Goldsmith could not recall how he knew Lamb was the other nurse involved but that he spoke to her at the nurse's desk where she was working and "asked her did she and [Marshall] hang blood on a patient without checking at the bedside, and she said yes. I asked her, 'Where do we check blood?' She says, 'At the bedside.' And I said -- and again, I don't remember the exact words, but that that needs to be done at the bedside. And she said that she agreed and that she would do that from now on." (Tr. 2942.) As described above, I find Goldsmith's testimony unreliable for several reasons including as here his

admission that he could not really recall what was said. Therefore, to the extent his testimony differs from York's, Marshall's, and Lamb's it is not credited.

Marshall testified that Goldsmith pulled her into the copy room and asked her if she had checked the blood for the transfusion she had just hung. Marshall responded that he had seen her check it with Lamb at the nurse's station and that Goldsmith did not respond to her comment. (Tr. 1239.) Lamb testified that Goldsmith came to her about an hour after she check the blood with Marshall and asked about checking the blood and said, "You know you are supposed to witness in the room," and Lamb responded that "she did know that and she was sorry that she did not do it." (Tr. 1548.)

Marshall continued to care for patient SF for the remainder of her shift and stated that she went into the room briefly about 5 minutes after she started the transfusion, to have visual confirmation that patient SF was doing okay. She did not converse with the patient. Marshall was required to record patient SF's vital signs on the transfusion card after 15 minutes and did that from the monitor at the nurse's desk. Marshall sent the nurse's aide to take patient SF's temperature and Marshall recorded it on the transfusion card with the other vitals at the nurse's station. At 6:15 p.m., Marshall ended the transfusion. Patient SF and her family members made no comment to Marshall about the transfusion when she ended it. Patient SF had no negative transfusion reaction to the blood. (Tr. 1231-1232; GC Exh. 2.)

York stated at some point, charge nurse Goldsmith came back in patient SF's room and said he had spoken to the nurses and he would follow up. (Tr. 447.) This incident occurred at 12:50 p.m. and Goldsmith did not notify any higher management officials or file an incident report before he left after his shift ended at 7:00 p.m. Goldsmith contended it was his intention to file an incident report, but he was unable to recall any reason why he failed to file one that day, other than being busy during his shift.

3. The initiation of the investigation

On September 12, Goldsmith went to work to teach a class. During a break he saw Linda Crumb, the acting ICU director at that time, and mentioned the patient complaint to her. According to Goldsmith, he informed Crumb he was intending to write an incident report on the situation, but Crumb testified that she directed him to file the incident report. (Tr. 2943, 2971, 3052.) Goldsmith's recollection was that he filed the report that day, but the electronic incident reporting system did not record it as being entered into the system until September 13. (Tr. 2944; R. Exh. 4.)

Typically, Crumb as the unit director would perform an investigation into a performance issue and communicate with the chief patient safety and quality assurance department overseen by Ames. If significant discipline or discharge was recommended, the director would then seek the input of senior management such as the VP of patient services, VP of HR, and the CEO. Although this is the process utilized to investigate staff performance issues that is evident through the comparable discipline evidence discussed below, it is not the process taken in this case. Also as discussed below, this investigation was not handled through the typical patient complaint process. (Tr. 3049.)

Shortly after Crumb's conversation with Goldsmith, Crumb relayed the conversation to vice president of patient services, systems, chief nursing officer Debra Raupers. Raupers directed Crumb to have Ames investigate the incident as a "serious safety event" instead of it being handled by director of patient and customer relations, Jacqueline Barr, who testified that "all the compliments, complaints and grievances that patients have about the organization come to me." (Tr. 2878.) Respondent called Barr as a witness with regards to the allegation of the removal of union literature from a bulletin board, but intentionally avoided asking her any questions about how patient complaints are typically investigated or any investigation or handling of patient SF's complaint in this matter. Respondent's counsel adamantly

objected to Counsel for General Counsel questioning Barr about the typical patient complaint process and why this incident was not investigated through that process. (Tr. 2905.)

Later in the hearing, Raupers testified that some patient complaint process was followed regarding this incident and that she attended the final meeting in that process, yet she claimed ignorance of that process in general and specifically in this case stated that Barr would have the information. (Tr. 3597-3598.) But when questioned further Raupers stated that complaints about an RN's care under this process would go straight to her and that she attended the meeting with John Rudd, CEO, John Turner, patient SF and her husband, and Jackie Barr pursuant to this process. Thus, I can only conclude that Raupers is well aware of the normal process for patient complaints and what if any of that process was followed in regards to patient SF's complaint. (Tr. 3600-3601.) Her unwillingness to admit that she had such knowledge, further causes me to believe that this incident was handled in an unprecedented manner, not based upon the nature of the complaint, but based on Marshall's involvement in the situation.

Furthermore, Respondent did not provide any evidence that it has issued any discipline as a result of a patient's complaint about a staff member's dismissive attitude, lack of "bedside manner," failure to ease a patient's concerns, or failure to follow procedure. Despite Raupers' Crumb's, and Ames' testimony expressing outrage that Marshall was dismissive and failed to ease patient SF's concerns about the blood transfusion, Respondent's intentionally omitted evidence concerning this issue. Therefore, I conclude that Marshall's failure to ease patient SF's concerns about her safety and/or her dismissive attitude that resulted in the patient complaint was not a basis for which Respondent would have disciplined or discharged her.

Raupers directed Crumb to assign the investigation of this matter to chief patient safety officer and director of quality and patient safety Karen Ames, because it was a "serious safety event."[20] (Tr. 3054, 3450.) The evidence does not support that this was a near miss, precursor event, or a serious safety event based upon the definitions used by CMC. "A near miss is a situation that could have resulted in an adverse event, but did not, due to timely intervention or by chance." (Tr. 2702; R. Exh. 55, pg. 7.) A precursor event actually reaches the patient and it may or may not result in harm. (Tr. 2703.) A serious safety event actually results in some type of permanent harm and it involves a deviation from a standard. (Tr. 2704.) Here the right blood was verified for the right patient, so there was never an event that could have reached the patient.

As the director of quality and patient safety, Ames oversees a department of six employees who monitor the incident reporting system to ensure compliance with regulatory/safety standards. (Tr. 834, 861-863.) Ames only spends about 5 out of her average 50 hour work week reviewing incident reports with her staff and could only identify a few investigations in which she was directly involved in the actual investigation (i.e. when a patient hit an employee, a patient fell, a chemotherapy incident, and her predecessor had investigated a wrong cite surgery). (Tr. 830, 848.) Although the record is unclear, each of these situations appears to have involved some actual harm, and therefore, a type of possible liability risk for CMC not involved in this situation. Despite the fact that these other investigations appear to involve actual harm, Ames stated that she had never been involved with an investigation that rose to as high of a level of risk as the incident in the instant case. (Tr. 836.) While the dire consequences of transfusing incompatible blood to a patient are undeniable, and, as discussed below, Marshall's, Lamb's and other ICU nurses' practice of verifying the blood at the nurses' station and not having 2 RNs verify the patient's identification at the bedside does add an element of risk that the transfusion policy strived to eliminate. That does not change the fact that patient SF was never at risk in this particular situation. Marshall

[20] I note that in each of the other discharges that Respondent presented as comparable evidence discussed below, the director or manager of that department conducted the investigation and recommended the discharge.

obtained the correct blood, verified that it was the correct blood for her patient with another RN, identified her correct patient, and administered it to that patient. Thus, I find Ames', Crumb's, and Raupers' testimony about being very upset with the severity of this situation contrived, especially when the reaction to the 2012 incident, discussed below, where a patient did almost receive the wrong blood was in Ames' own words not a classified as a "serious safety event" because no harm came to that patient.

On 1:43 p.m. on September 13, Goldsmith finally entered an incident report into CMC's electronic system concerning the September 11 transfusion. Goldsmith's factual description states:

> [Patent SF] called me into her room and asked me to close the door. She then asked me if it was common practice to check a patient's ID bracelet before starting blood, I informed her it was.
> She then informed me that the nurse, Anne Marshall had hung the currently infusing blood without checking her ID.
> I noted that the attached paperwork had all the appropriate initials and vital signs. I approached Anne to ask if she had checked the patient ID against the blood before starting infusion. She informed me that she and another nurse had used patient's sticker sheet at the nurses station to confirm the information. We then had a brief discussion on the importance of checking blood at patient's bedside. Anne [Marshall] stated that she understood and would do so in the future.
> I also spoke with Loran Lamb, the cosigner on the paperwork. She verbalized the correct procedure for checking blood and stated that she would be sure to so from now on. (R. Exh. 4, pg. 2.)

In order to encourage staff to report incidents so that safety issues can be addressed, CMC uses a "just culture algorithm" in reviewing incidents. (Tr. 3175; R. Exh. 58.) CMC has used this model since 2010 after shifting away from a culture of blame that discouraged staff from reporting incidents. (Tr. 3178.) The just culture algorithm provides for a labyrinth of factors to determine whether an employee should be re-educated and/or consoled, coached, remediated, or punished. (Tr. 3179.) In this situation, CMC contends that the factors in the flow chart for "duty to follow a procedural rule" were applied. Under such an analysis "an employee will be subject to disciplinary action when they have acted with reckless disregard toward the risk associated with non-compliance." (R. Exh. 58, pg.3.) There is no evidence that CMC specifically followed the steps in this analysis. Instead, the evidence shows that CMC followed its related procedure for determining whether a "red rule" violation had occurred. "Red rules are key tasks that if not performed the right way can lead to dangerous outcomes." (GC Exh. 17.) To determine if a red rule violation has occurred:

> The Director of the service will contact the Chief Patient Safety officer (x4436) and together they will investigate the violation to determine if it is human error, at risk or reckless.
> Question : How do we determine if it is human error?
> Answer: To determine human error, we will ask if the individual knew the right thing to do, if they intended to do the right thing and followed the right process. We will also evaluate the following:
> -Training- was the error a result of a lack of training?
> -Environment/Design- was the error a result of factors such as a high workload, constant interruptions or poorly designed equipment?
> -Process/Policies-
> -Was the error a result of a poor process?
> -Was the error a result of a procedure that does not make sense?
> -Was the error a result of a procedure that is hard to follow because it is poorly

written?
-Are others able to follow the process/procedure?
-We will evaluate the process and policies last - asking questions regarding policies and procedures first may shut down communication.

If the behavior is classified as Human Error we want to console the individual and develop a system that will prevent future errors. (Id.)

4. CMC conducts interviews with patient SF

Ames testified that she interviewed Patient SF in person on September 14 while she was still hospitalized. Raupers and Ames called patient SF on September 16 to again discuss the incident. Patient SF was ultimately unavailable to testify due to her medical condition. (Tr. 3225-3226.) Therefore, all the evidence concerning patient SF's statements about what occurred during the incident at issue constitutes hearsay. This evidence consists of Goldsmith's summary entered into the incident reporting system on September 13; Ames' summary of her conversation with patient SF on September 14, which she entered into the incident report system; Raupers' summary of her and Ames' telephone conversation with patient SF on September 16, which was emailed to Ames on September 20; and patient SF's September 19 email recounting the situation. These documents were admitted into the record as business records. (R. Exhs. 4, at pg. 2 and 3; 5; and 6.) As noted above, I find patient SF's email the most reliable evidence of her account of what occurred on September 11, as it more closely aligns with the first-hand testimony of York and Marshall than the summaries of conversations others had with her concerning the incident.

Patient SF's email, and York's and Marshall's testimony all assert that patient SF questioned Marshall about doing the 2-RN verification of the blood. Neither patient SF's email nor York's testimony specifically state that Marshall did not individually look at patient SF's identification bracelet or orally ask her name and date-of-birth. There was no record evidence of any effort on CMC's behalf to clarify this distinction with patient SF, as noted below, CMC was clearly aware that it had not verified this information with York, and York testified that she could not specifically recall. Thus, I credit Marshall's testimony that she individually verified patient SF's identity before starting the blood transfusion as there is no direct evidence to the contrary, and as York testified it had been Marshall's practice with other procedures that she witnessed Marshall perform for patient SF.

5. Review of transfusion cards, incident reports, and patient SF's other transfusions

CMC conducted a review of documentation surrounding blood transfusions. CMC's review of transfusion cards, despite frequent failures by RNs to correctly complete the transfusion cards, did not evidence that any other RNs had failed to perform a 2-RN bedside check. (Tr. 3257.) Of course, that information is impossible to derive from the transfusion cards. As discussed below, these cards are completed in a rote checklist manner in coordination with the RNs' established practice of performing the associated tasks without necessarily technically complying with the transfusion policy. As discussed above, the transfusion card itself does not comply with the policy.

CMC conducted a review of the numerous transfusion related incident reports and found no mention of failure to perform a 2-RN bedside check or any other portion of the verification process. (R. Exh. 23.) I note that these and the other incident reports in the record are the result of some issue arising (i.e. wrong patient, documentation for wrong patient, documentation incomplete, allowable time for safe transfusion exceeded, transfusion reaction not noticed by RN, wrong medication or dose, failure to record that care or medication was given, etc.), and therefore are qualitatively different than the incident report in this case. For example, on April 22, 2016, an RN put the wrong patient's identification sticker on the request form that was sent to the laboratory for a unit of blood. The error was caught by the laboratory and corrected.

Similarly, on January 15, 2014, and January 2, 2015, RNs ordered blood and provided the laboratory identifying information for the wrong patient. (R. Exh. 23, pgs. 22, 25, and 38.) In each case of these cases, the RN and the RN's unit were re-educated.

CMC also reviewed patient SF's transfusion records showing that she had received 22 units of blood products on 11 dates prior to September 11. (R. Exh. 7.) Although the documentation does not list which specific hospital unit where these transfusions occurred, only the last 3 occurred in the ICU. On the 3 occasions that patient SF received transfusions in the ICU other than the incident at issue the transfusions were performed by an RN who was precepting another RN. (Tr. 1308-1309, 1737, 3406-3407.) Precepts are assigned the same patients as the RN training them. Each of the ICU nurses who testified stated that when they are precepting an RN they do not perform the desk check. Instead they fail to follow the policy in another manner by doing the entire check at the bedside. The precepting RN is fully available to accompany the primary RN into the patient room and there are other procedures involved in the transfusion to be reviewed with the precept.

6. The preparations for the discharge of Marshall began before CMC's investigation

I find that CMC intended to discharge Marshall as early as September 16, before it conducted the steps required by its "red rule" violation investigation standard. CMC's VP of HR Brian Forrest was unwilling to state when the decision was first made to discharge Marshall, but sometime on or before September 16, Forrest directed his secretary to draft a discharge letter for Marshall. (Tr. 2010-2011; GC Exh. 22.) His secretary emailed the draft letter to Forrest on September 16. The letter states that Marshall falsified the transfusion card and that she has been "untruthful in other previous situations including the July 1, 2015 suspension," which was found to be a violation of the Act by the Board. *Cayuga Medical Center,* supra at slip op. 1. The draft also states that her conduct was a violation of the Red Rules and "with past history it is clear that this relationship is not working appropriately." (GC Exh. 22.) Significantly, there is no evidence of any discharge letter being drafted with regard to Lamb at that time. Lamb was never the focus of management and was simply a casualty of circumstances.

During his testimony, I initially gave Forrest the benefit of doubt in his claims that due to the number of documents he drafts, he was unable to recall the date of when he first determined Marshall would be discharged and first drafted her discharge letter. As his testimony continued it became apparent that he was intentionally evading questions posed by General Counsel by contending that he did not recall dates and other information. For example, when he was questioned about referencing Marshall's suspension, which was found unlawful in the prior case, he claimed he was not aware that the suspension had been found unlawful by ALJ Goldman's decision, which had issued during the intervening time. He also claimed that he had only read "a little bit" of the decision but admitted that he had criticized the logic of very specific language found in ALJ Goldman's decision. (Tr. 1017, 1018.) It is highly unlikely that a VP of HR would uncover this language in the JD-104-16 decision without unearthing the administrative law judge's findings concerning Marshall's suspension.

Forrest's demeanor on the stand exhibited as much disdain for Board processes as he exhibited in an email communication concerning the administrative law judge's decision in JD-104-16 where he referred to the Board as possessing a "complete Union bias" and the administrative law judge as an "activist" judge. (Tr. 1017; GC Exh. 23.) Because of Forrest's unrelenting refusal to give full and direct responses to most of the questions posed to him, I do not credit his testimony that he did not recall when he decided to discharge Marshall over this incident. I find that the credible evidence supports that the decision to discharge Marshall was made by the September 16 email, before any of the steps of the "red rule" investigation analysis had occurred.

7. The initial peer review meeting

CMC cited the findings of its Peer Review Committee as justification for its discharge of Marshall and Lamb in their respective discharge meetings. CMC's peer review committee has existed since 2015 and is meant to be comprised of RNs from each of the hospital's units. Participation is voluntary and must be approved by the RN's unit director. The committee has never been fully staffed and did not have an RN from the ICU at the time in question. (Tr. 2841, 2843-2844.) Typically, a committee member is assigned a particular incident to report, reviews the patient's medical file, and presents the information at a monthly meeting. After reviewing the situation, the members discuss the issues, and then attempt to come to consensus and complete a rating form for the incident by asking whether any prudent, experienced nurse: (1) would have done the same thing, (2) might have done the same thing, or (3) would not have done the same thing. If the committee is not able to come to a consensus they select "it's indeterminate" on the form. (Tr. 2850).

On September 19, an emergency peer review committee meeting was convened by Crumb. Terri MacCheyne, the director of maternal-child health, maternity, and pediatric units who chairs the committee was not present. The meeting was led by Crumb who explained the patient complaint about not having the bedside check performed, and provided the committee with the transfusion policy and patient SF medical records regarding the transfusion. (Tr. 3126, 3142-3143.) The peer review committee minutes are:

> "The blood transfusion policy was reviewed. The documentation related to the concern was reviewed. The committee recommends:
> 1. Further Investigation by Administration.
> 2. Placement of a print name area on transfusion card as signatures are often unable to be read.
> 3. Documentation improvement by EMR [electronic medical record] group and laboratory."

(GC Exh. 69.) On September 20, Crumb informed Raupers by email that the Nursing Peer Review determination that "by the documentation [they] could not determine if policy was not followed[.] [T]hey recommended staff needed to be interviewed. They had concerns about our need for better safety check tools for blood administration, bar code etc." (Tr. 3123, 3137; GC Exh. 68.) Ames did not attend the first peer review committee and stated she was not aware that the committee recommended the RNs involved be interviewed. (Tr. 3395.)

I note that Crumb's September 20 email also states: "Mary Jane is here!! I explained what was going on and she is interviewing potential travelers."[21] (GC Exh. 68.) Thus, it appears that CMC was already interviewing possible replacements for Marshall and Lamb.

8. Ames' interviews of four ICU nurses

On September 20 before speaking to either Lamb or Marshall as is indicated by the investigation model, Ames interviewed ICU RNs Terry Ellis, Joan Tregaskis, Anita Tourville-Knapp, and Ananda Szerman while they were working on the ICU floor. The stated reason for these interviews was to determine their understanding of the transfusion policy with regard to the 2-RN bedside check. (Tr. 3248; R. Exh. 9.) Ames did not take notes during the interviews but sent an email to Crumb and Raupers containing her summary of these conversations as follows:

[21] The term travelers refers to RNs that contract to work at a hospital for a particular period of time and are paid per diem travel expenses.

> Terry E- she knows this is the practice, and it is done at the bedside however she can't say that there has never been an occurrence when it was done away from the bedside such as at the nurses station. She did say challenges are when patients are on isolation- she stated maybe there needs to be more education on what to do in this instance. She also said she thinks a bigger problem is not checking the ID bracelet and instead bringing in the chart and using a label. I asked her why this would happen instead of looking at the name bracelet, and she said it is easier than sometimes trying to "dig the wrist out". Reiterated to her the importance of not using labels.
>
> Joan- she verbalized her practice of always checking the blood with another RN at the bedside. She can't speak to if it happens all the time with other nurses.
>
> Anita- she stated she knows this practice and she does do the two person check at the bedside. She also admitted that there may be an occasion when it is not. I asked her an example of a time when it might not be done at the bedside, she stated if they are really busy and you are grabbing another nurse to do the check. I asked her if checking at the bedside takes any more time than at the nurses station and she stated that it probably doesn't. I reminded her that it is the best practice and our policy. She verbalized understanding.
>
> Ananda - stated she understands the policy and recently heard about the need to do it at the bedside. I asked if she ever did the RN check away from the bedside and she gestured to the nurses station area and then she stated " you can still see the patient" (which in this case has nothing to do with the issue). I then pointed to where the documentation on the transfusion record stated "at the bedside and asked if that meant she (and other nurses) documented differently if they were not doing the RN check at the bedside. She just shrugged and said no. l reminded her that doing the check at the bedside is our policy and safer for the patient and she stated 'message received".
> (R. Exh. 9.)

I credit the testimony of RNs Tregaskis, Tourville-Knapp, and Szerman.[22] They were aware that CMC discharged Marshall and Lamb for conduct that they admitted to performing. They were clearly testifying against their own professional interest and in the presence of Raupers, CMC's director of nursing who ultimately decided to discharge Marshall and Lamb. Each testified that in their conversations with Ames they communicated that they and in some cases other ICU nurses did not always perform the check at the bedside. None of them wavered in their testimony to this regard. (Tr. 913, 1081-1082, 1705.)[23] Even after cross-examination questions about how their conduct may constitute falsification of a medical record, Szerman and Tourville-Knapp did not retract their testimony. (Tr. 1123-1124, 1735.)

At the time Ames interviewed them, the RNs knew that some concern had been raised about how transfusions were performed. Szerman testified that at the beginning of the shift safety meeting on August 20, charge nurse Terry Ellis had informed the RN staff "to make sure [they] had two nurses

[22] Neither party called Terry Ellis as a witness nor claimed that she was unavailable to testify.

[23] Szerman's testimony that she had communicated to Ames that Marshall's and Lamb's conduct in performing the blood transfusion was not an isolated incident is corroborated by RN Lousie McGarry's testimony. On October 7, McGarry, an RN in the emergency department, attended a staff meeting with Raupers and Crumb. McGarry asked whether Marshall's and Lamb's failure to do a 2-RN bedside check was an isolated incident but her question was not answered. Later that same day McGarry transported a patient to ICU and asked Szerman if the incident with Marshall and Lamb was a one-time aberration. Szerman replied that she specifically informed Ames that it was not an isolate occurrence in ICU. (Tr. 1090, 1155-1157.)

hanging the blood at the beside." (Tr. 1081-1082.) This testimony is consistent with Ames' note that Szerman had "recently heard about the need to do it at the bedside." Similarly, Tregaskis stated that she knew why Ames was asking these questions because her colleagues had already been discussing that an issue had arisen because Marshall and Lamb had not done the bedside check. (Tr. 973.) In a November 10 email that Ames sent to Raupers and Forrest, she notes, "Another intial (*sic*) step taken was that we instructed [interim ICU manager] Mary Jane Boss (immediately after incident occurred) to add this as a topic to daily safety briefings." (GC Exh. 78.) Despite knowing on August 20 that the bedside check had become an issue for management, all four of the nurses informed Ames that Marshall's and Lamb's failure to perform a 2-RN bedside check was not conduct isolated to them.[24]

Szerman testified that she told Ames: "Well, I did today because they reminded us to do it with two nurses at the bedside at safety, but normally I don't always do it that way." "But she kept asking me and I kept saying the same thing. And then I was just really busy and getting annoyed and so I said, "Message received," and went about my business." (Tr. 1082-1983.)

Tourville-Knapp's recollection is that Ames approached her while she was working in ICU and showed her a transfusion card. Ames asked whether she follows the policy, and Tourville-Knapp responded: "I always check at the desk in front of the room of the patient, and do all the pertinent checks, but may not have that second nurse go in the room with us." Ames asked her when this occurred and she responded when they were busy or an RN was watching another patient. (Tr. 1705.)

Tregaskis testified that "Karen Ames walked up to me as I was sitting at the desk and asked me what I do when I'm giving a blood transfusion. And I commented that I knew what this was about. And she asked me where I checked blood. And I said in the room, but that there are times when it's really crazy and it just can't be checked in the room." (Tr. 913.) "I think that I said that I couldn't speak for others. [I was] implying that I was only speaking for myself." (Tr. 980.) Ames did not ask for any specifics about when she had not checked blood in the room or clarification about what she meant when she said she could only speak for herself. Tregaskis commented that she had never given blood to the wrong patient and Ames responded that she was not asking about that. (Tr. 913).

I give no credit to Raupers' and Ames' claims that their investigation yielded no evidence that other RNs had failed to perform a bedside check before transfusing blood. Their interviews with patient SF and York had told them that Marshall claimed to have performed the check at the desk and that RNs in ICU were not required to do a 2-RN bedside check and if one occurred it must have been because the RN was new. This apparently raised enough concern that they instructed management staff to provide re-education in the shift meetings which was occurring at least by September 20 before they spoke to any RN other than Goldsmith about the issue. As discussed below, they personally provided this re-education at staff meetings after their interview of Marshall on October 4 where Marshall raised the issue of their knowledge of this practice.

Setting aside that I credit the three interviewees' testimony that they admitted to Ames that they had not always complied with the bedside check, which was not fully reflected in Ames' summaries, I find that no unbiased reader of Ames' emailed summary could conclude that the interviews revealed no evidence that other RNs had failed to do the bedside check. Ames testified, "From the nurses that I spoke to in the ICU, including the ones I spoke to individually, the two huddles that we did, we did not find that there

[24] The RNs were instructed to perform the bedside checks before being interviewed and before either Lamb or Marshall were interview despite CMC's own investigation procedure noting: "We will evaluate the process and policies last - asking questions regarding policies and procedures first may shut down communication." (GC Exh. 17.)

were any inconsistencies with that practice. Every RN stated they knew what the policy was. They stated they did it at the bedside. They were not able to give any concrete examples of it not being done at the bedside." (Tr. 3342, 3487-3488.) Ames' testimony on its face contradicts her own notes. Ames apparently understood the folly in this claim, and modified her testimony from stating that there was no evidence that others violated the transfusion policy to that no RN reported a specific incident of such a violation. (Tr. 3342.) Yet, there is no evidence that any RN was ever asked to elaborate on a specific incident or that the red rules analysis requires evidence of specific incidents rather than knowledge of a systemic problem before determining that re-education is appropriate.

9. CMC chose to ignore that failure to fully understand and comply with the transfusion policy was widespread

If Ames or Raupers pursued the issue of whether the RNs truly knew and practiced the blood transfusion policy, they would have found, as became pellucid during the hearing, that the confusion and lack of full compliance with the transfusion policy was not isolated to Marshall, Lamb, and the four RNs that Ames interviewed.

As early as September 15, Raupers, Ames, Crumb, Forrest, Dr. Sudilovsky, and other administrators had received an email chain discussing the issue of noncompliance with the transfusion protocol as a systemic problem. A member of the laboratory staff initiated the email discussing a HemoCue operator red rule violation in the ICU where the RN repeatedly scanned the wrong patient's sticker in relation to a test. For this to have occurred, the RN would have had to scan a sticker from a chart and not the identification bracelet on the patient. After a discussion of the events the email states:

> In my observation, the nurses are regularly making this error. This does not appear to be a one-off. They are clearly teaching each other short-cuts. This is the exact same thing that happened with the transfusion and 2 nurses were involved there. (Tr. 1073, 3571; GC Exh. 31.)

Anntoinette Burger, administrative director laboratory services adds to the chain:

> I agree with Dawn that typically these dangerous shortcuts are more commonplace than we'd like to think. We see it in our own lab processes. If an employee takes the shortcut 99 times out of 100 and nothing bad happens, it reinforces that the shortcut is ok. . . . (GC. Exh. 31.)

Another administrator forwards the chain to Forrest stating: "In light of the blood transfusion issue in ICCU, I wanted to make sure you were aware of this string of emails." (GC. Exh. 31.) The lack of compliance with the policy despite occasional reviews through the hospital's HealthStream education program was the information that the risk management department that Ames oversaw was charged with uncovering and correcting. (Tr. 861-863.) I find that instead of actively attempting to uncover and correct any general lack of compliance with the policy, CMC intentionally avoided such information as it would undermine their argument that Marshall and Lamb should be discharged. CMC's attempt to avoid compiling this information is evident in an email exchange between Anna Bartel (Bartel), the quality project manager working under Ames, and Ames. Bartel wrote:

> Starting 9/30/16, the PI department will observe random blood transfusions and audit compliance per the policy. Findings will be reported to Deb Raupers, Linda Crumb and Karen Ames. We will attempt to make these audits covert. . . . For on-going training, our current method is only when the policy changes (as it did in July of this year). I do not feel that this is sufficient. There is an option to add it to the annual NPSG required

> annual training. If this is desired, Barbara Goodwin will add it to the curriculum. I would recommend that it remain in that training indefinitely. I also feel that we should verify that blood transfusion is on the unit based training on all applicable units. Barbara could confirm this for us.

Ames' blunt unexplained email response was: "*Don't do anything yet*." (emphasis added) (Tr. 3408-3410; GC Exhibit 74.)

Despite the testimony of Sudilovsky, Raupers, Ames, and Crumb exclaiming the seriousness of not complying with the transfusion policy, Ames responds to Bartel, who has just raised concerns about the lack of training in this area and the need to investigate further, "Don't do anything yet." I find that CMC intentionally avoided uncovering evidence that there was widespread lack of compliance with the transfusion policy and that a need for more education existed. I further find that CMC was motivated to deny the existence of this evidence, and the underlying issue of why there was noncompliance with the policy, because it contradicted their basis for discharging Marshall and Lamb.[25]

10. Witness testimony establishes that failure to fully understand and comply with the transfusion policy was widespread

The testimony of Szerman, Tregaskis, and Tourville-Knapp was corroborated by other ICU nurses. RN Mary Day started at CMC in 1999 and has worked as a full-time RN on the day shift in the ICU for 14 years.[26] Day was assigned on average 2 to 3 patients per month that required one or more blood transfusions. Day was the first witness called and despite rigorous cross-examination remained consistent with her testimony. She testified that she and other nurses who work the ICU day shift failed to fully comply with the transfusion policy and transfusion card due to lack of recall and understanding of the policy, as an established practice in ICU, and as a judgment call based upon other patients' needs. I credit

[25] Despite the numerous questions about whether RNs had ever submitted incident reports or reported a failure to perform a 2-RN check to management, CMC's knowledge of RNs failure to comply with transfusion policy before the incident is a red herring. Although I am not fully convinced that unit managers and directors were not aware of the blood transfusion practices of their units, it is unnecessary for me to reach a conclusion on that issue. The 'just culture discipline" analysis does not require prior knowledge on management's behalf of employee failure to perform procedures accurately. It requires an investigation as to why the conduct may have occurred including a review of the policy at issue and an investigation of the employees' understanding and the application of that policy. The whole point of the analysis is to uncover and prevent future incidents through re-education, when after-the-fact it is determine that re-education of the individual and/or the staff is required.

[26] Unless otherwise stated, I credit the testimony of the RNs called by General Counsel and Respondent about the details of their interactions with patients and other CMC personnel despite their inability to recall the date or time frame when these interactions occurred, the name of the patient, or other specific details. The RNs consistently testified to being assigned 2 or more patients and performing numerous nursing procedures during each of their 12-hour shifts. I do not find this inability to recall other specifics surrounding their testimony about performing blood transfusions or other patient care procedures, lessens the witnesses' veracity as to their recollections of how they performed or witnessed others perform blood transfusions on one or more occasions. It would be a very rare person who could recall the surrounding details with more accuracy under the circumstances. For example, when pressed during cross-examination about why she could not remember more specifics about incidents when the secondary RN did not perform the second blood transfusion check at the bedside with her, RN Mary Day (Day) consistently and frankly explained, "It was such a common practice that no one [incident] stands out." (Tr. 186.) Only RN Jacqueline Thompson could recall a specific date and patient when testifying about a blood transfusion that she performed, but unusual circumstances surrounded that procedure. Thompson was able to recall the blood transfusion because it occurred close to the discharges, she had been "floated" from the medical unit to work in ICU, she cared for a long term patient that she cared for on other days with a very unusual disorder, and she was surprised by how ICU charge nurse Scott Goldsmith initiated the blood transfusion verification. (Tr. 1765-1767, 1770.)

Day's testimony as it was consistent despite her concerns about her own employment. When asked questions with potential consequences for her and her colleagues, such as whom she had witnessed not doing the bedside checks or whether her completion of the transfusion card without performing all the bedside checks constituted falsification of medical records, Day's facial expressions and demeanor was that of resolve to answer honestly despite her fear of how her testimony could affect her and her colleagues' employment and licenses to practice nursing. Day occasionally paused before answering the questions that had more direct implications for her or her colleagues. In these pauses it was apparent to me from her demeanor that she was gathering her courage and continued to testify truthfully to the best of her ability despite the possible negative effects towards her employment or her relationships with her colleagues. *Flexsteel Industries*, 316 NLRB 745 (1995) (finding the credibility of current employees enhanced when testifying against their current employers).

Regardless whether Day was acting as the primary or secondary RN, she and another RN did a thorough check at the nurses' station outside of the patient room where they checked the order against paper work on blood bag--name, date-of-birth, patient number, blood type, order number, number of units, donor numbers, and the patient's informed consent form was signed and in the file. (Tr. 70, 82.) Day initialed and signed the transfusion card at the nurses' station with the other RN doing the same except for the start time which was filled in after the transfusion was started. [27] (Tr. 86.) Depending upon who the secondary nurse was and/or how critical that nurse's patients were, the secondary nurse may have or may not have gone into the patient room and perform the second check. (Tr. 73.)

As the primary nurse Day, as Marshall testified that she had done, always performs a partial second check in the patient room re-verifying the patient's identifying information including the patient's name and date-of-birth. With significant frequency, the secondary RN with whom Day performed the initial check at the desk would not accompany her into room to perform any portion of the bedside check. (Tr. 72-73, 89, 185-186, 278, 282.) When acting as the secondary nurse Day, like other RNs on the dayshift in ICU, might or might not have gone into the patient's room to perform the second check depending on the circumstances, including the severity and needs of the patients assigned to her. If Day did not go into the room to perform the second check as the secondary nurse, she would watch the primary nurse take the blood product into the patient's room (patients' names and room numbers are visible at nurses' station monitors) and at least go to the doorway of the room and verify verbally with the patient, his or her name and date-of-birth. (Tr. 73, 166-177, 175,) If the patient was unable to respond, Day went into the patient's room and checked the patient's identification bracelet. Although Day made it her practice to check the identification of the patient either orally or by checking the bracelet, she witnessed other secondary RNs performing no part of the bedside check like Lamb had done.

Day stated that she had not noticed the language embedded in the transfusion card that states, "Below information must be verified at Patient Bedside." Lamb, Marshall, former 4th floor telemetry unit manager Michael Doane, and ICU RN Jennifer Cole, who was called by Respondent, also testified that they were unaware of this language on the transfusion card before the discharges. (Tr. 81, 350, 352, 1407, 1599-1600, 1606, 2806-2807.) Lamb testified that she was often very busy at work and tried to focus on what was most important and could miss something. (Tr. 1600.) The rather rote nature with which these transfusion cards were completed is apparent from the evidence of omissions by RNs in signing/initialing the cards correctly. For example, the relatively small sample of transfusion cards submitted into the record evidences these omissions. (R. Exh. 65, at pg. 2; R. Exh. 68, at pg. 5; R. Exh. 69, at pgs. 3, 5, 6, and 9). Although it appears not all such errors are caught and corrected, on some occasions the laboratory did catch such errors and initiated an incident report. The record contains 28 incident reports with errors

[27] Although step 13 of the blood transfusion policy requires that the 2 RNs check that the informed consent is in the file at the bedside, none of the ICU nurses testified that they brought the file into the patient room to perform all the checks required under step 13. (Tr. 82.)

ranging from failure to return the transfusion card to the laboratory, failing to complete any portion of the card, to failing to initial or sign one or two locations on the card. (GC Exh. 11(a)-(bb).) Doane testified that in an effort to not overlook one of fields that required initialing, the 4th floor telemetry unit, at one time, had developed a template card to place over the transfusion card to verify the RNs had initialed all the blanks before submitting the transfusion card to the laboratory.[28] (Tr. 1471.) Based on the record as a whole and credibility findings with regard to each of these witnesses, I credit their testimony that they were not aware that this specific language was embedded in the transfusion card.

Day's testimony that 2 RNs did not consistently perform the bedside check is corroborated by Christine Monacelli, an RN at CMC in ICU for 16 years. (Tr. 344, 348, 356, 402-403.) Before learning of the discharges and the extensive questioning about the policy during the hearing, Monacelli believed that the entire check was supposed to be performed at the patient bedside. (Tr. 576.) Despite her understanding that the policy required the check to be performed at the bedside, she only performed the check at the bedside when she believed it was safe for her other patients or when she was precepting a new nurse. When she was the primary nurse, the check was almost always done at the nurses' station with only her performing the bedside check of identification information. (Tr. 594-595.)

Shawn Newvine was the director of the ICU from 2003 until about April 2015 when he left CMC because of the number of extra shifts he was required to work at CMC and his new position is closer to his home. (Tr. 2458-2461.) RNs Day, Monacelli, and Tregaskis recalled Newvine acting as the secondary RN in assisting them with blood transfusions as he was unusual in his role as director, because he would assist the RNs in performing direct patient care. This was especially true for the year prior to his resignation from CMC when the ICU had ongoing staffing shortages. (Tr. 90, 92, 362, 364-365, 667, 671-675, 927, 983). Day and Monacelli both recalled times during this period that Newvine acted as the secondary in checking blood with them because no other RN was available. On these occasions, Newvine performed all of the checks and initialed all the correlating boxes on the transfusion card at the nurses' desk. Newvine verified which room the RN was taking the blood and in most cases, watched which room they entered. From his location at the nurses' desk he was able to see the name of the patient in each room on the monitor. Day and Monacelli stated that Newvine did not enter the room with them on these occasions and did not perform any verification at the patient's bedside, but Day and Monacelli performed individual identification checks at the bedside. (Tr. 365, 368-369.) Day's and Monacelli's testimony never wavered on this issue despite rigorous cross exam. Like was customary on the unit, no incident report was filed concerning Newvine's failure to perform the bedside check. (Tr. 186.)[29]

[28] I credit Doane's testimony as to the use of this template card, because an incident report from November 16, 2015, regarding 2 short stay surgery unit RNs' failure to properly complete a transfusion card notes that the staff was "re-educated to use our template hanging at charge nurses (*sic)* desk." (GC Exh. 11(r).)

[29] Newvine, who is now employed as the manager of a surgical unit at another hospital, denied that he has ever failed to comply with the 2-RN desk check and the 2-RN bedside check for a blood product transfusion or that any RN who worked under him in the ICU at CMC had failed to comply with both of these checks. (Tr. 2458, 2465-2466, 2470.) I do not credit Newvine's testimony. Newvine's presentation was overconfident as if he came to present well-rehearsed testimony. Additionally, he was not able to recall the name of any RN with whom he had performed a blood transfusion verification, although he stated that he did them as often as once per week at CMC. When he was given Day's name by Respondent counsel, he was still unable to affirmatively testify he had ever performed a transfusion verification with her. (Tr. 2468-2469.) Similarly, Newvine could not recall other policies at CMC, for example, how many nurses are required to take narcotics out of the pyxis machine. (Tr. 2475.) I find it unlikely that Newvine recalled CMC's transfusion policy, which is unique in comparison to the national standard and the experiences of the RNs who had worked at other institutions, when he could not recall other policies. Newvine's lack of recall for other details leads me to conclude that his overly confident testimony, with regard to the blood transfusions in which he participated, was not honestly based upon his recollection. At first glance, it may appear that Newvine would have no motivation to testify untruthfully in this matter because he works for another employer. Yet, admitting he had failed to comply with the transfusion policy could be detrimental to his current

Much like the ICU RNs had developed a practice that was not compliant with the transfusion policy, so had RNs on the 4-north medical unit. RN Jacqueline Thompson has worked on the 4-north medical unit since 2011 and is occasionally floated to other units. I credit Thompson's testimony because her of direct, matter-of-fact demeanor. Also, due to the specific circumstances involved as discussed above, Thompson was able to recall details about the events to which she testified. Thompson testified that prior to January 2017, everyone Thompson had ever hung blood with on the 4-north medical unit had always failed to do any verification of the blood product outside the room with the exception that the primary RN verified there was an order and a consent in the patient's file. (Tr. 1781.) At one time, Thompson used to bring the chart into the room to do the entire check there, but someone told her that she was supposed to check the consent and the order outside the room. She had changed her practice accordingly. (Tr. 1802.) Thompson stated that before going into the patient's room, she and her colleagues never took the unit of blood and transfusion card, which is folded so that none of the identification information is visible, out of the resealable plastic bag in which it is transported from the laboratory to the nurse. (Tr. 1805-1806.) Thompson and her colleagues often did not stop outside the patient's room to check the consent and order, causing the secondary to accept the primary RN's assertion that those documents were in the file. (Tr. 1809.) Thompson and the RNs on her unit completed the entire transfusion card in the patient room. (Tr. 1806.)

Thompson's testimony was corroborated by 4-north medical unit RN Katherine Race, who was called to testify by Respondent. Race's practice was to check the consent and order outside the patient room and then do the remainder of the check in the patient room. (Tr. 2826, 2833.) Race was hired in June of 2015 and was taught this method when she was precepted. (Tr. 2831-2832.)

On September 5, Thompson was assigned to the ICU for her shift and requested that Goldsmith assist her in verifying a blood product for a transfusion she was performing. At the nurses' desk Goldsmith removed the unit of blood and transfusion card from the re-sealable plastic bag in which it had been transported from the laboratory. Goldsmith was apparently preparing to do the verification check at the desk before entering the patient room. Not realizing that the policy required a more detailed check outside of the patient room than verifying that the order and consent were in the file, Thompson commented that they should be doing that in the patient room. Goldsmith raised no objection. They skipped the desk check and only performed the bedside check as was Thompson's practice. (Tr. 1765-1766, 1768, 1794.)

Similarly, the witnesses called by Respondent did not fully comply with the transfusion policy, but testified that they performed at least a portion of the 2-RN bedside check. For example, Laurel Rothermel, who has worked for CMC as a "per diem" RN in ICU since July of 2015, performed all of the required checks before entering the room but only checked some of the required items at the bedside. Rothermel testified that in the approximately 15 transfusions in which she has participated at CMC, she and another RN always did a full check of the various identifiers at the nurses' station and then went to the bedside to check the personal identifiers on the patient's wristband—name, date-of-birth, and account number. (Tr. 2766-2767.) Rothermel testified that she gave patient SF a blood transfusion with ICU RN Andrew Barnes, who she was precepting, and that they had performed the same limited bedside check. (Tr. 2770.)

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managerial position. Furthermore, one of his reasons for leaving CMC was the number of extra shifts he was required to work. This coincides with Day's and Monacelli's testimony that Newvine participated in these verification processes within a year before he left CMC at a time of short staffing and Newvine, who was also under time constraints, did not enter the patient's room to perform the second verification at the bedside. (Tr. 667, 671-675, 927, 983.)

Barnes corroborated Rothermel in his account: "Me and Laurel compared the blood to the order outside of the room. I specifically remember standing at the desk right outside the room and doing that. We went in and we did all the checks with the patient, checked the wristband, you know. Asked her her name, her date of birth, the account number." (Tr. 2785.)

Respondent witness Jennifer Cole, a team leader RN in ICU on the night shift from 2011 until she was promoted to a house supervisor on February 1, 2017, testified that until recently she had performed an abbreviated beside check. It had been her practice to perform a full check with another RN at the nurses' desk then both RNs would verify only the patient's name, date-of-birth, and account number against the transfusion card at the bedside. (Tr. 2799.) Cole stated that she "was very much a stickler for not signing that box until we were in the room and actually did that," which implies that those she worked with would not have necessarily followed that requirement of the transfusion policy or documentation on the transfusion card if she did not insist they did. Within 6 months before she testified, which would have been around the time Marshall and Lamb were discharged, someone pointed out to her that the transfusion card language that states, "Below information must be verified at Patient Bedside." Cole, like other RNs including Marshall, Lamb, Day, and Monacelli, had never noticed that language before. Since that time, she, like Thompson, Day, and Monacelli, has altered her practice to comply with the language of the transfusion card, which as discuss above does not actually comply with the transfusion policy. (Tr. 2800.)

Cole testified that she had performed transfusions with Scott Goldsmith. (Tr. 2802, 2812.) Cole's description of how she used to perform and now performs transfusions is not consistent with Goldsmith's testimony that he always followed the transfusion policy's 2-tier, 2-RN verification process. Similarly, Thompson's testimony that Goldsmith discontinued the desk check and performed only the bedside check contradicts his testimony. After being questioned again about his practice in blood transfusion verification, Goldsmith modified his testimony by stating that is generally how he did it. (Tr. 3011-3012.) Oddly, despite being the charge nurse, and therefore, the most likely to not have to attend to immediate patient needs, Goldsmith was unable to list many RNs with which he had performed transfusion verifications and very few other RNs listed him. This is consistent with Marshall's testimony that she asked him to assist, but he said he was too busy. Goldsmith was asked whether he had heard of any instances where a failure to perform the 2-RN bedside verification had not taken place before September 11. Goldsmith responded, "It would be—nothing specific. If I did, it would be rumors and hearsay." (Tr. 2927.) As stated before, I do not find Goldsmith's testimony reliable.

As Day, Monacelli, and Dr. Sudilovsky realized after being questioned while testifying about the transfusion policy in relation to the transfusion card, following the transfusion card does not equate to following the policy. Upon realizing this inconsistency Dr. Sudilovsky dismissed portions of the policy as optional and stated it is "most crucial that [blood] type and patient's arm band be compared directly at the bedside." (Tr. 1913-1914.) Cole, Rothermel, nor Barnes, at least with regards to the transfusion verification that he performed with Rothermel for patient SF, testified that they had verified the blood type at the patient's bedside. Respondent did not question Rothermel, Barnes, or Cole about not fully complying with the transfusion policy and falsely initialing that they had performed portions of the verification process at the bedside. Indeed, Respondent's questions of witnesses noticeably shifted from full compliance with the policy like those asked of RNs Day and Monacelli at the beginning of the hearing to whether they performed at least the identification of the patient portion of the policy at the bedside. Similarly, after several of the ICU RNs testified it was their practice to fill out the transfusion card absent the start time at the nurses' desk before entering the patient's room, Respondent counsel started asking the witnesses to agree that it was not important when or where they completed the transfusion card, just that they did everything on the card.

Thus, I find no evidence showing that any RN who testified performed the 2-tiered, 2-RN check totally correctly, nor did they fully complete the transfusion card correctly prior to the discharges. I find the credible evidence shows that the ICU RNs, like Marshall and Lamb, most often performed a 2-RN thorough check at the desk and then one or sometimes both of them performed a name, date-of-birth, and sometimes an account number check at the bedside. In ICU, a more thorough check at the bedside occasionally occurred but usually only when a RN was precepting a new RN, which is consistent with how Marshall had responded to patient SF when she questioned the lack of a 2-RN check.

11. Lamb's interview

Between September 11 and 20, Lamb had worked at least one shift as scheduled. (GC Exh. 68.) On September 20**,** Lamb received a call from John Rudd's secretary asking her to go to Karen Ames' office before her shift the next day. Lamb asked if the ICU knew she would not be reporting on time and the caller said she would check into it. When Lamb was asked to report to Ames, she believed that Ames had additional questions about an incident that occurred six months earlier where a patient for whom Lamb had provided care died during the next shift under another RN's care.

On September 21, Lamb attended a meeting in the education room with Ames and Crumb. Lamb, concerned about operations on the ICU floor, clarified whether the unit knew she was not going to report on time. Crumb called ICU to let them know. At the outset of the meeting, Ames said there had been an incident report about a patient complaint concerning a blood transfusion where 2 nurses had not performed the bedside check. Lamb immediately realized that they were referring to the blood transfusion verification she had done with Marshall and that Goldsmith had told her the patient had complained to him. Lamb became very upset and apologetic. I credit Lamb's testimony that she became so upset when learning the topic of the meeting, because she believed that she would be fired for the incident, because it involved Marshall. Lamb knew CMC wanted to get rid of Marshall and probably her as well for supporting the Union. Lamb was upset with herself because she allowed herself to be vulnerable to discharge through association with Marshall.

Despite knowing she would likely be discharged, Lamb answered their questions honestly and did not offer any additional information. Ames asked her what the blood policy was and Lamb went through the steps that she performed at the desk with Marshall and then said you go to the patient's bedside and again stated all the steps. Ames confirmed that Lamb had performed all the required HealthStream classes. Ames confirmed that Lamb was aware of the possible harm to a patient if the patient were to receive incompatible blood. Lamb told Ames that she had not gone into the patient's room to perform the check because she was busy caring for a critically ill patient in room 2 and another patient who had a pacemaker surgically implanted. (Tr. 1551.) I also credit Lamb's testimony that she did not explain to Ames and Crumb that other ICU RNs performed the check the same way, because under the circumstances, she was afraid it would jeopardize their jobs as well. (Tr. 1553.) Ames and Crumb left the room for a few minutes and then came back and told Lamb that she was suspended with pay pending investigation. Lamb verified that Ames' notes of what occurred at the meeting were basically accurate as to what was said. (Tr. 1636-1642; R. Exh. 11.)

Within 90 minutes of when Lamb left CMC, Ames called and asked her to return to CMC to discuss the transfusion card. Lamb, a widow with dependent children, had just explained to her children that she expected to be discharged despite her belief that she performed her job well. Lamb told Ames that she was too distraught to return to CMC at that time. (Tr. 1554-1555.) Later that same day Brian Forrest called and scheduled an appointment with Lamb for the next day and gave her information about the New

York State Department of Education that has authority over nursing licenses. Lamb requested to bring a personal attorney to the meeting which Forrest denied.

On September 22, Lamb met with Brian Forrest and Linda Crumb. Lamb was asked to verify that it was her signature and initials on the transfusion card, which she did. No other questions were asked of Lamb about completing the transfusion card, and Lamb did not offer any further explanation. Lamb requested a letter of suspension. Lamb stated that she wanted a letter explaining the suspension because she did not understand what CMC was asserting the reason for the suspension was because, "This is what we always did, they knew it." (Tr. 1556.)

On September 23, Lamb sent Crumb an email requesting the suspension letter and received an auto-reply saying Crumb was out of the office, but Lamb continued to check for a response. By 3:30 p.m., Lamb and Marshall were locked out of their CMC email accounts but other coworkers still had access. After a series of calls, Lamb was allowed to pick up her suspension letter the following Tuesday which briefly recapped the information that management sought to verify in the meetings it conducted with her. (Tr. 1559; GC Exh. 40.)

12. Dr. Sudilovsky's opinion

On September 22, Raupers met with Dr. Daniel Sudilovsky, chairman of the pathology laboratory medicine and director of the laboratories, concerning the blood transfusion at issue. Sudilovsky's demeanor and testimony evidenced a pompous attitude in general and specifically towards RNs. For example, when he was confronted with his own inability to recall the transfusion policy that he is responsible to approve and enforce, he stated that he is very busy and had read hundreds of pages of documents since he reviewed the policy the day before inferring that his work is more demanding than that of RNs caring for critical ill individuals in ICU. Despite Sudilovsky's demeanor, I credit Sudilovsky's testimony about what he was told by Raupers and the information that he was ignorant about when he rendered his opinion on the situation.

Raupers discussed the patient complaint with Sudilovsky and Lamb's admission that they had performed the check at the nurse's station but she did not accompany Marshall to the patient room to perform the bedside check. Sudilovsky could not recall if he reviewed the incident report which contained Goldsmith's explanation of the event at the time he discussed the issue with Raupers, but at some point had reviewed the incident report. (Tr. 1928.) Sudilovsky claims to have been unaware of the identities of the nurses involved at that time. No documents or other evidence contradicts this claim.[30] Based upon Raupers' assertions about RN education and that such conduct had not occurred elsewhere and that the staff involved knew how to do it right and chose not to, his response was to send an email and identical letter stating that he would no-longer authorize the staff involved to perform blood transfusions. (Tr. 1883; R. Exh. 17(a)-(b).)

[30] Dr. Sudilovsky's December 1 email contains the following language: "I could use your advice on how to handle the blood utilization minutes from our last committee meeting. I have not signed the document yet. The portion I am concerned about relates to discussion of some sensitive blood transfusion events and could use some guidance in terms of how to handle the contents and what is the discoverability of these documents?" Unfortunately, General Counsel did not receive these documents until after Sudilovsky had testified and did not recall him despite the allowance to do so. (GC Exh. 28(a).) Although the "last meeting" occurred in November, Respondent's Counsel asserted that this email referred to the discussion about removing the transfusion card from units of blood in the October meeting minutes. The audiotape of the November meeting had been taped over and minimal notes were taken during that meeting. (Tr. 1997-1998; GC Exh. 28(b)-(c).) There is no further testimony or documentary evidence in the record concerning this email. Despite the troubling language contained in this email, I am unable to make an evidentiary finding with regard to it due to insufficient evidence.

Sudilovsky admitted that he depends on nursing staff management to oversee training. He has no knowledge of what training or practice actually occurs. (Tr. 1897.) Sudilovsky admitted that Raupers had not shared Ames' notes from her interviews of the 4 ICU nurses who all indicated that the bedside verification was not consistently performed. (Tr. 1957-1958; R. Exh. 9.) As discussed above, CMC had avoided uncovering more evidence of RNs failing to perform the blood transfusions consistent with the policy that it could have shared with Sudilovsky. Raupers of course did not have share Marshall's claim of verifying patient SF's identity at the bedside, because Marshall had not been interviewed at that time. Raupers, having given Sudilovsky only the information that she wanted him to receive and having gotten the reaction she wanted from Sudilovsky, had not provided him with the arguably exonerating information that she had at that time.

Sudilovsky stated that if he had known of other RNs who had done the same thing, he would have acted the same and denied them access to administer blood transfusions. (Tr. 1959-1960.) I give no credit to this speculative statement. Despite Sudilovsky's initial reaction to this information, I find it impossible to believe that the CMC would not have negotiated with Sudilovsky to find another solution other than to limit the ability of so many of its ICU nurses from performing a task that would likely necessitate their transfer to another unit or discharge, especially when it had recently experienced staffing shortages in ICU. Furthermore, Dr. Sudilovsky walked back his conviction, that his response to Marshall's actions was appropriate, if she indeed had verified the patient's identity at the bedside. Sudilovsky viewed Lamb's conduct of not even entering the room as more egregious contrary to other CMC management. (Tr. 1969-1971.)

Despite referring to the incident at issue as "a clear near miss/or potential serious harm scenario" in his letter regarding the incident, Sudilovsky testified that a "near miss" is defined "where a wrong bag [of blood] gets close to the wrong patient," which to Sudilovsky's knowledge only occurred in 2012. This case did not qualify as a "near miss" because at no time was the wrong blood close to patient SF. (Tr. 1954-1955.) In spite of testimony elicited from Sudilovsky about the possible licensure effects of Marshall's and Lamb's conduct on the hospital, the hospital is only required to report incidents where the wrong blood actually reaches the patient. (Tr. 1962; R. Exh. 55, pgs. 9-10.) Thus, Marshall's and Lamb's conduct of verifying and administering the right blood to the right patient did not trigger or arguably come close to triggering a reporting function. Therefore, I find the testimony solicited from Sudilovsky about the dire possible effects of this incident partially contrived.

13. The second peer review committee meeting

On September 23, at either Ames' or Raupers' request, Terri MacCheyne held a second emergency peer review committee meeting regarding the transfusion at issue. (Tr. 2838-2839, 2858.) Only five committee members attended this meeting. Half of the committee consisted of RNs from the maternal-child unit, which only performs 10 or 12 transfusions each year, and no member from the ICU. Instead of a committee member presenting information, Raupers and Ames presented at the meeting. MacCheyne testified that the peer review committee does not typically have access to the incident report system and usually reviews only the information in the electronic medical report. In this meeting Ames read the patient's email regarding the blood transfusion, and Raupers apparently read or discussed Goldsmith's account that he entered into the incident report and some report of Lamb's account of the situation. (Tr. 2862, 2874; R. Exh. 16.) However, Marshall's contention that she independently verified patient SF's identification at the bedside was not presented to the committee as she had not been interviewed. The committee's summary of its review of the matter strikingly reads like Ames' summary of her conclusions of her interview with Lamb although the form on which the peer review committee recorded its determination did not follow this same type of assessment. (R. Exh. 16.)

I find no evidence in the record as to the significance of the committee's findings. The one document in the record setting forth the parameters of the peer review committee provides no evidence of the role of the peer review committee or its determinations in employee discipline. (R. Exh. 59.) Nor is there any evidence that the committee's findings had ever been considered in another employee's discipline. Yet, Lamb and Marshall were informed of the committee's determination in their discharge meetings and it was mentioned in early drafts of their discharge letters but management ultimately determined it was inappropriate to reference the committee's conclusions in the final discharge letters. (Tr. 1060, R. Exhs. 20(a)-(b) and 26(a)-(b); GC Exhs. 27 and 36.) The peer review committee's report noted that there was no adverse outcome and no effect on the patient. The committee's recommendations included "Feedback to Caregiver – Opportunity for Improvement." No portion of this form contemplates recommending discipline. Thus, I accord no weight to any contention that the peer review committee's conclusion required that management take any disciplinary action against Lamb or Marshall.

14. On-going preparations for Marshall's and Lamb's discharges

On September 29, John Turner emailed CEO John Rudd the "latest employee letter, with some edits from Brian [Forrest]." This email contemplates informing CMC employees, physicians, and volunteers that Marshall and Lamb had been discharged well in advance of Marshall's interview in this matter. Turner admitted that he knew Marshall had not been interviewed yet because of a schedule issue, but he had drafted this letter because he "knew the investigation was completed. . . .all the facts had been gathered." A later version of this letter was ultimately sent to all CMC employees, physicians and volunteers on October 6.

On September 30, an RN who worked on 4-south telemetry unit had performed a blood transfusion but failed to initial any of the required locations on the transfusion card. Unit Manager Rebecca Simon sent an email to Kansas Underwood and Linda Crumb informing them that she had counseled the RN and documented the counseling in his file. Kansas Underwood forwarded the email to Crumb and Raupers and stated that the other RN involved in the transfusion and the patient verified that he had performed all of the verifications but was very nervous and did multiple checks before initiating the transfusion. (Tr. 2327; GC Exh. 52.)

15. Marshall's interview

On October 4**,** Marshall returned to work after a previously planned vacation and reported to the ICU as usual. Marshall's name was not posted on the assignment board. Soon after she arrived, interim ICU director Mary Ann Boss escorted her to a meeting in human resources. Marshall, who unlike Lamb, knew what to expect from this meeting and requested that RN Day be allowed to accompany her, which Boss allowed. Upon arriving at the human resources department, Marshall went to the restroom and Brian Forrest sent RN Day back to work. Ames, Crumb, Forrest, and Marshall were present for the meeting which was audio recorded by management. Marshall's testimony about what occurred during this meeting was limited but consistent with the recording. As with the interview with Lamb, Ames asked cursory questions to verify that Marshall had completed the HealthStream training for blood transfusions in July and that Marshall understood that the consequences of transfusing the wrong blood type to a patient. Then the discussion turned to the transfusion policy. Ames focused on Marshall's failure to perform the bedside check, even after patient SF questioned Marshall's failure to do so. While Lamb was caught off guard as to the subject of her investigatory meeting, Marshall was prepared for Ames' questions. Although Marshall was never directly asked what occurred that day, Marshall explained that she and Lamb had performed all of the checks at the nurses' station and then she went into the room alone to hang the blood. Marshall stated that she asked patient SF her name and date-of-birth and checked her

identification bracelet. Ames responded that patient SF stated that she had not performed this check and when patient SF questioned Marshall about it Marshall told patient SF that they did not do it that way in ICU. In response to the Ames' questions about whether she had violated the policy, Marshall repeatedly stated that other RNs had frequently violated the policy in the same manner and had told Ames that they had failed to follow the policy. Ames never denied that other RNs had informed her that they failed to do the bedside check, but pointed to the patient's experience with other transfusions as evidence that the policy was followed by other RNs. (R. Exhs. 20(a) –(b).) Marshall contended that CMC should follow its practice and determine why multiple RNs were failing to follow the transfusion policy and re-educate them. Ames then questioned Marshall about the transfusion card and the statement on the card that directs that certain portions of the checks be performed at the bedside. Marshall, like other RNs, stated that she had not noticed that line on the form before then. (Tr. 1240-1242; R. Exhs. 20(a) - (b).) CMC points to Marshall's defensive stance as evidence of lack of credibility. I find that Marshall took this stance because she inherently knew that she needed to defend herself in part based upon prior actions CMC has taken against her and in part because Lamb had already been suspended. It was this willingness to speak out and defend her positions on management's course of action on many issues that had fed CMC's animosity towards her.

After meeting with Marshall on October 4, Raupers, Crumb, and Boss called a safety huddle meeting with the on-shift ICU nurses. Mid-shift safety huddle meetings are usually reserved for imminent safety issues such as a violent patient or mass casualties. (Tr. 1153.) At this meeting they discussed the transfusion incident, read the patient complaint email to the ICU staff, and emphasized the 2-RN bedside check. Ames and Raupers then asked the staff to report any other instances where they were aware that the 2-RN bedside check had not occurred. Not surprisingly, the RNs who had started hearing rumors as early as September 20 about management's investigation into the transfusion incident did not volunteer any information.

Raupers testified that she made the final decision to discharge Marshall and Lamb. Like Ames, Raupers testified that their investigation yielded no evidence that other RNs had failed to perform a bedside check before transfusing blood. As stated above, I do not credit this claim based upon Ames' email to Raupers summarizing the interviews with the 4 ICU RNs. I find that Raupers' was under great pressure to portray the discharges as non-discriminatory acts, and therefore, under-emphasized some evidence and over-emphasized other evidence. Raupers' 2016 evaluation noted:

> [Raupers] also did an exceptional job dealing with the labor organizing threats we faced this year. She handled herself in a professional manner in some very trying circumstances. She specifically handled the issue of the blood transfusion well. She was able to separate the fact that the *individual* was an union organizer from the facts of the case and determine the appropriate recommended course of action and discipline in this case.[31] (emphasis added)[32] (Tr. 3604-3605; GC Exh. 75, pg. 4.)

I find that her evaluation evidences the strong motivating factors for Raupers to not be truthful in her testimony and to paint the discharges as non-discriminatory acts. Raupers was the second to last witness called, followed only by one short rebuttal witness called by General Counsel. Raupers had the benefit of hearing all the other witnesses testify because she attended the hearing as CMC's representative. For the most part, she testified to her conclusions of the information found in the investigation and her impressions of the statements made by Marshall in the October 4 and 6 meetings discussed above. I

[31] I give no credit to the claim that the fact that Marshall was a union organizer was separated from the decision to discharge her.

[32] This further emphasizes that this whole matter was about Marshall, and Lamb was a side note.

found Raupers' testimony particularly self-serving. Raupers found fault with virtually everything Marshall stated and the manner she stated it. Raupers seemed to have translated CMC's perception that Marshall lies about union issues into a belief that Marshall lies about everything. Raupers remained nervous throughout her testimony, rubbing a small rounded, smooth wooden cross like one would do with a "worry stone." Based upon Raupers' demeanor on the stand and inconsistencies reflected in the evidence, I do not credit her testimony that she found no evidence of other employees violating the policy.

16. Lamb's and Marshall's discharge meetings

On October 5, Brian Forrest called Lamb and requested that she attend a meeting later that morning. Crumb and Raupers conducted the meeting which was audio taped. (Tr. 1559.) Lamb's recollection of the meeting, although not as detailed, was consistent with the recording. (Tr. 1563.) Raupers led the meeting and started off explaining the delay caused by Marshall's unavailability. Then Raupers read the portion of the patient's complaint letter concerning the transfusion. Raupers explained that the patient's sister, who is an RN, was present and had questioned Marshall as well, which is inconsistent with York's testimony that only her sister spoke to Marshall, Marshall's recollection of the interactions, and SF's email about the incident. Raupers appeared to be attempting to convince Lamb that CMC was correct to discharge her. Raupers explained that Ames verified that other nurses knew the policy to perform the 2-RN bedside check, that it was a national standard, and that the patient had 10 blood transfusions before the one in question all with two nurses at the bedside. Three of those transfusions were in ICU. Raupers reviewed the peer review committee's finding that competent practitioners would have handled the case differently. Raupers stated that she questioned the peer review committee if there is equal onus for performing the bedside check and they said there was. Raupers never told Lamb about Ames' interviews of other RNs, but stated that she had. When Lamb started to reply that she had not mentioned other RNs failing to do the bedside check to them, both Raupers and Crumb cut her off assuring her that she had. Raupers' tone with Lamb was conciliatory throughout and she expressed other nurses' concern for Lamb. Raupers told Lamb that another nurse informed her that Lamb may consider resigning. Lamb became very emotional over making the decision to resign versus being discharged, but she felt it was the better choice as she her children's only source of income. Raupers recommended resigning because she would receive her vacation time and continued insurance benefits. She became so emotional that Raupers and Crumb let her sit alone for a few minutes. Lamb ultimately decided to resign and wrote a one sentence statement to this effect. (Tr. 1564, GC Exh. 41.) Lamb continued to express grief over leaving the job and her coworkers**.** *Raupers responded, "And they are so upset about this. This is going to be so difficult because they're, they're angry that I can't treat you and Anne [Marshall] differently to be honest."* Raupers went on to offer Lamb employee assistance services if she needed them. (R. Exh. 26(a) and (b).)

On October 6, Raupers and Forrest met with Marshall to inform her of the outcome of their investigation. Raupers denied that other RNs had informed management that they did not always perform the bedside check. Raupers also stated that the 10 transfusions patient SF had received before the one Marshall administered had all involved a bedside check, and that Marshall's claim that she performed the bedside check contradicted patient SF's account. She also informed Marshall of Charge Nurse Goldsmith's account of what she said to him. Interestingly, during the October 4 meeting, they never asked Marshall her account of what occurred in the patient room nor was Marshall asked about her conversation with Goldsmith about the incident. Marshall interjected objections to statements made by Ames about patient SF's recollection of the events, but she never was allowed to give a full statement of what occurred and was never asked about her conversation with Goldsmith. Therefore, Raupers' statements during the discharge meeting concerning Marshall's account of the interactions with patient SF and Goldsmith were for the most part baseless. (R. Exhs. 29(a)-(b).) Marshall was shown the entire patient letter. She objected to some of the patient's complaint having nothing to do with her and disputes that the sister

could have checked the blood because she took the transfusion card with her to the nurses' desk. Marshall, having learned that Lamb was allowed to resign, had prepared a resignation letter which she placed face down on the table. Marshall took the termination letter that CMC prepared for her and left. (Tr. 1249; GC Exhs. 36 and 37.)[33]

17. Email to employees announcing discharges

On October 6, CMC issued its finalized letter about this incident by email to all of the CMC employees, physicians, and volunteers concerning patient SF's complaint. The letter states:

> Dear CMC Employees, Physicians, and Volunteers,
>
> Patient Safety continues to be a key priority for Cayuga Medical Center. With that in mind, I want to make everyone aware of a recent incident involving a blood transfusion in the Intensive Cardiac Care Unit. This is a very high-risk procedure that requires two RNs to verify the identification of a patient at the bedside and check the patient's armband. The patient in this case submitted the following written complaint describing the incident. This patient has given us her permission to share her letter in order to continue our focus on patient safety education and the importance of speaking up.
>
> *"In July I started needing to have blood transfusions. From day one the nurses talked me through the protocol they would be following whenever they administer a blood product for me. call for blood, wait. Get Tylenol and Benadryl. Blood arrives, 2 nurses are in the room with the blood. They scan my name band, they ask me my name and birthdate. They read my name and number off my wrist and compare it to the paperwork. They then read the numbers on the blood bag and compare it to the paperwork numbers. If everything matches, then they start the blood.*
>
> *Unfortunately I ended up in the hospital on September 5th. All my blood numbers were very low and I had an infection somewhere. In the next few days numerous blood products were hung and the protocol was followed. On September 11th it was determined that I would need a bag of blood. Nurse calls, we wait. My sister and aunt were in the room. The nurse comes in hangs the bag and starts the blood. I looked at her and said "What about the protocol?" And she said "Oh, we did that at the desk."--and left the room. My sister, who is an RN in the state of Maine, ran over to the blood to check the numbers. I said "This isn't how it's ever been done." The numbers checked, so I relaxed, but when the charge nurse came into the room, I voiced my major concerns to him. All previous nurses had made me aware of the protocol and led me through it---this nurse did none. The charge nurse told me he would speak to the nurse, and let me know after he did. I need the hospital to be aware of this breach of protocol and seriousness I felt being vulnerable in my bed."*

[33] On October 20, based upon CMC's determination that Marshall's and Lamb's conduct constituted "professional misconduct," Raupers reported to the New York State Education Department's Office of the Professions that Marshall and Lamb knowingly falsified medical records and deliberately violated established safety standards. Respondent attempted to admit the Regional Office of Professional Discipline's letters referring these allegations to the Prosecutions Division of the Office of Professional Discipline. I rejected Respondent's offer of these letters, because they did not constitute a final decision by that body and give no basis for the determination to make that referral. Although I find these referrals highly suspicious under the circumstances, I note that the question of whether these referrals were retaliatory actions in violation of the Act is not before me. The referrals were not alleged by General Counsel as a violation and the issue was not fully litigated. (Tr. 3576.)

> In response to this patient complaint, we conducted a full investigation that included notifying our Chief Patient Safety Officer, convening a team of front line nurses not connected with this case, interviewing the patient and family, a full review by our pathologist, etc. I would like to thank the entire team for doing a comprehensive job looking into this case. From this investigation, we determined that the two ICCU nurses, who were involved in administering the blood transfusion, willfully and recklessly disregarded the well-established safety procedures and then falsely documented in the patient record that the procedures were followed. These two nurses are no longer employed at CMC.
>
> We are fortunate that the patient in this case did not suffer any physical harm, but this incident serves as a lesson and a reminder to all of us that there can be no shortcuts when it comes to patient safety at CMC.
>
> Maintaining a just culture where patient and employees can speak up freely about patient safety issues will always be priority one for us. We are committed to doing the right thing for our patients and community.
>
> Thank you,
> Karen Ames
> Director of Quality and Patient Safety and Chief Patient Safety Officer
> (GC Exh. 7.)

This action by CMC was so unusual it resulted in email responses from a physician and an RN, both noting the unprecedented nature of the letter. (Tr. 1777; GC Exhs. 20 and 70). Employee Matthew Roy emailed Brian Forrest and director of medical rehabilitation Bernice Miller questioning the issuance of the email notifying all CMC employees, physicians and volunteers of the termination of Marshall's and Lamb's employment. Unsatisfied with Forrest's first response, Roy replied again questioning Forrest if CMC's communication and email policies had been violated by the email contending that it was in effect the sharing of employees' discharge notice. Bernice Miller spoke with Roy and sent a follow up email defending Roy's conduct stating that "[Roy's] email was sent only because of the very public stance of one of the individuals [Marshall] has taken." The email goes on to state that Roy raised concerns "that CMC leadership made an example of this employee which could lend to people not reporting." In encouraging Forrest to meet with Roy to attempt to ease his concerns, Miller noted that "he is a terrific employee…. I don't think that [Roy] is pro union I think he is pro people and feels uncomfortable with this very public approach." (GC Exh. 70.) Again, I find that CMC's hostility towards those who favor unionization is evident.

VP of public relations John Turner contends that in 2009 a similar communication was sent out after a wrong site surgery had occurred for which staff had received some unspecified discipline. (Tr. 891.) No other witness recalled or equated that communication with the above email. Another very long-term employee recalled another letter concerning patient care being distributed years ago before the use of email. (Tr. 3131-3132.) No other witness could recall any letter similar to this ever being distributed. (Tr. 543, 547, 833-834, 915, 1777.) Neither of these earlier communications is in the record.

When asked why CMC issued this letter on October 6 Ames inadvertently admitted that CMC was concerned about re-educating the staff on the transfusion policy. Ames stated, "[W]e knew that we were getting mixed messages from [Marshall], regarding her claim that staff were not doing it at the bedside. And we had already had the serious event back in 2012. So we wanted to reinforce the importance of this

practice." I find that CMC's "Just Culture Algorithm" discipline model would not allow for the discharges of Marshall and Lamb, if CMC directly admitted that Marshall's claims that others were performing blood transfusions in the same fashion as she did. For that same reason, Ames' denied that the interviews of other RNs in ICU had revealed this claim to be true. Therefore, CMC could not directly take actions to re-educate the RNs on its transfusion policy as the just culture/red rule analysis policy required and which had been the recommendation of Ames' own risk management employee.

18. Attempts to bolster the evidence

On October 14 VP of HR Forrest sent Ames an email stating: "If the opportunity arises in a visit with the sister [York] to see if she would provide a statement that would include a validation that Anne did not check her sister's wristband that could be helpful to us as Anne's latest has been saying that they are lying and the more proof we have the less she has credibility." Ames' responded: "I left her a voicemail last week with my phone number and email asking if she could send us a statement-i don't want to push her though so wasn't sure whether I should call her again." (R. Exh. 78, pg.1.)

Based upon this email exchange which occurred well after the discharges, Ames' testimony that before she recommended the discharges of Marshall and Lamb she had verified with York that Marshall did not individually check patient SF's identification is not credible. (Tr. 3390.) This assertion by Ames is also in direct contradiction of York's testimony that she is unable to recall whether Marshall individually checked patient SF's identification when initiating the blood transfusion, but did recall that Marshall had done so in administering other treatments to patient SF. (Tr. 487.)

Furthermore, I find no direct evidence that CMC ever clarified with patient SF if Marshall orally verified her name and date-of-birth and/or specifically looked at her identification bracelet or was in a position to read it. The email from patient SF does not clarify this issue, nor do any of the exhibits concerning interviews with patient SF directly address this question. York's testimony about patient SF's concerns and patient SF's email complaint centered around the failure of Marshall to perform the multi-step 2 RN bedside protocol with which she was familiar. Thus, I find no substantiated evidence in the record to support CMC management's assumption, as is evident in the email exchange between Ames and Forrest, that Marshall was lying in stating that she individually verified patient SF's identification before initiating the transfusion.

19. Ongoing confusion about the transfusion policy

On October 10, Jennifer Delmage, a hospital aide who mostly worked in ICU but was working in the short stay surgical unit, witnessed two RNs check blood at the nurses' station and then enter the patient's room without taking the patient file to the room. Delmage filed an incident report. (Tr. 312-314; GC Exh. 4.) The transfusion policy requires that the RNs verify at the bedside that the patient consent form is in the file, and Dr. Sudilovsky contended that this was a requirement. (GC Exh. 3, pg. 5.) Thus, by not taking the file into the room, the 2 RNs had broken the policy. Instead of finding even a minor violation of the policy, Director Bernice Miller noted that "the nurses followed protocol" and stated that the short stay unit had a practice of taking the file into the patient room, indicating that the practice was not a requirement and that the failure to do so in this incident did not result in a violation of the policy. I find that this statement reinforces that different units develop their own idiosyncrasies in performing procedures unless corrected. I further find that Miller's statement evidenced that it is at least not uncommon for directors and likely managers of units to be familiar with the practice of the RNs on their respective units. I note that none of the RNs who testified stated that they changed their practice in the presence of managers or directors. Only director Kansas Underwood testified about the blood transfusion

practice of the RNs on the units she directs and as discussed below, I do not credit her testimony in that regard.

RN Jacqueline Thompson could not recall the exact date but in about October or November 2017 she attended an RN staff meeting with 6 or 7 RNs. The meeting was conducted by Kansas Underwood, the director for 4-north medical and 4-south telemetry units. Underwood read the portion of patient SF's email that discussed the blood transfusion and stated that Marshall and Lamb were not discharged because of their union activity. Thompson told Underwood that the way Marshall and Lamb did the blood verification was how they did it in ICU and relayed her experience with Goldsmith. Underwood told Thompson she should have shared this information with her sooner. (Tr. 1774-1776, 1791.)

Underwood's recollection of this meeting was similar to Thompson's except that Underwood testified that Thompson had asked whether Marshall and Lamb were discharged for union activity, which she denied. Underwood contends she told Thompson that she should have brought the issue up earlier so re-education could have occurred. Underwood claims to have not known or asked with whom Thompson had performed the transfusion. Underwood claims that she did an initial search for the transfusion record but did not find the transfusion to which Thompson was referring. Underwood did not question Thompson about why she did not do the check the blood outside the room with Goldsmith as is required by the policy, and Underwood testified that she believed Thompson performed the verification pursuant to the policy. (Tr. 2241.) Underwood discussed Thompson's statements with Linda Crumb, but she could not recall any further follow-up. (Tr. 2339-2340.)

In about late December or January 2017, Thompson performed a blood transfusion with 4-north medical unit manager Crystal Chaffin (Chaffin), who has an office on the unit and spends approximately 20% of her shift on the floor interacting with patients and staff. (Tr. 1821-1822.) This is about the same time that version 8 of the transfusion policy was issued. As discussed above, Thompson had continued to only check the order and consent before entering the patient room. Although she had received the patient complaint and they had discussed the 2-RN bedside check, she did not realize she was omitting the more detailed desk check as it had not been discussed or at least she did not understand it. Chaffin showed Thompson that she had to perform the desk check before taking the blood into the patient's room. Thompson admitted to Chaffin that she had always been doing the check wrong. No incident report was submitted. Thompson is now doing the 2-RN verification check with her coworkers before entering the room. (Tr. 1783, 1785-1786, 1814-1816.) Respondent called Chaffin as a witness but did not question her about this this interaction with Thompson. Thus, I credit Thompson's version of these events.

Around this same time the 9th version of the blood transfusion policy was issued making the initial check outside of the room mandatory. Also around this same time, Underwood, the director over the unit in which Thompson works, conducted a staff meeting and announced a new policy requiring the secondary RN in transfusion verifications to be the charge nurse or a designee of the charge nurse to insure they followed the transfusion policy. As a result, Thompson is now performing the initial check with the secondary RN before entering the room. (Tr. 1783, 1785-1786.) Underwood claimed that the new policy was a result of incident reports noting a failure to fully complete transfusion cards that came to her attention in about the summer of 2016. Underwood claims that she met with Chaffin and decided to implement the requirement of charge nurses acting as the secondary RN in transfusion checks as a performance improvement strategy in completing the transfusion cards. (Tr. 2234-2235.)

I do not credit Underwood's reasoning for the changes in policy in the units she oversees. She testified that the change was in response to transfusion card errors which had been a focus since the prior summer. But the requirement that the secondary RN be the charge nurse or his/her designee was not implemented until after Thompson verified blood with Chaffin and Thompson admitted she was unaware of the 2-RN

verification before entering the patient room. About that same time Chaffin met with Underwood and the change was implemented. Underwood appeared physically distressed when being asked these questions by Respondent Counsel on direct. Her neck and face became red and blotchy and her physical movements were tense. I do not attribute her physical symptoms to the general stress of testifying, because all of these symptoms resolved when direct exam by Respondent Counsel ended. The symptoms never reoccurred during cross examination which did not include questions about the application of the transfusion policy on the units she directs.

Furthermore, Underwoods' claim that these changes occurred in the summer of 2016 is not consistent with the charge nurse meeting agenda dated December 1, 2016, discussing transfusion card errors since the last meeting and her plan to bring a transfusion card to the next staff meeting with RNs. (Tr. 2238; GC. Exh. 43.) No other minutes reflecting such discussions at earlier meetings were offered. Thus, I credit Thompson's testimony that prior to the implementation of this policy in late December or early January 2017 at least a significant portion of the RNs who regularly worked on the 4-north medical unit were not fully compliant with the transfusion policy's requirement of a 2-RN verification before entering the patient's room. I also find that the implementation of the rule that the secondary nurse to the transfusion verification should be the charged nurse was implemented to correct this and possibly other errors occurring with the transfusion policy on that unit.

20. Comparable discipline evidence

a. The 2012 "near miss" blood transfusion incident

The October 2, 2012 "near miss" incident is the only other blood transfusion verification for which CMC contends an employee was disciplined/discharged. The incident occurred on 4-north medical unit and was reported to the unit manager Crystal Chaffin, who worked for CMC as a staff nurse for 18 years and was promoted to the manager position shortly before the 2012 incident. RN CR,[34] the primary nurse conducting the transfusion, had been with CMC since the beginning of 2012 and the other two RNs involved, Seth Mead and Nate Newman, had recently been certified as RNs and completed orientation. RN CR asked Mead to retrieve the unit of blood from the blood bank and gave him the requisition, and then another staff member requested that he retrieve a second unit of blood for another patient.

At the blood bank Mead was told he could only courier the blood for one patient at a time, so he pocketed one requisition and received one unit of blood. Mead testified that when he returned and handed the blood to CR, he stated the name of the patient for which it was intended and CR somehow expressed agreement although it was not her patient's name. Based upon the records of this event and Mead's testimony, Mead made no mention to CR that he had taken two blood requisitions to the lab and was sent back only one patient's blood or that he said anything further to clarify that he was giving the blood to the right nurse. (Tr. 2537-2539.) Sometime after receiving the blood, CR asked Newman to verify the blood with her and proceeded into her patient's room. Newman went to the desk to get the patient's file before returning to the patient's room. CR took the wrong blood into her patient's room and before performing any verification hung, spiked and primed the tubing for transfusion but had not started the flow of the blood through the tubing before Newman entered the room to assist with the verification process. (Tr. 2508.) Almost immediately thereafter before the check was performed Mead returned with the second unit of blood which was actually for that patient and informed them they had the wrong blood. (Tr. 2355-2363.) The incident was immediately reported to Chaffin and she went to the patient's room, had the unit of blood removed and sent back to the lab.

[34] Out of sensitivity to the privacy of former employees who were not called to testify, I refer to them only by their initials.

On October 3, 2012, Ames received an email questioning whether this event could be considered a serious safety event and whether a root cause analysis (RCA) could be performed regarding the event. Ames responded, "Yes, this is huge near miss. It would not actually be classified as serious safety event as there was no patient harm, but that is from a classification standpoint only-this certainly is serious and thankfully it was caught before something happened. I am happy to set up an RCA . . . ." (GC Exh 53c, pg. 9.) Despite stating that she would perform a RCA, Ames did not initiate one.

Chaffin testified that her supervisor at the time spoke to then VP of HR Allen Peterson and they decided that because of other incidents involving CR that her employment would end.[35] (Tr. 2365.) CR had a significant history of procedural errors which suggest the conversion of narcotics. The documented reasons for CR's departure are as follows:

> -overdosing a patient on narcotics
> -signing excessive narcotics in non prescribed *(sic)*
> doses out of pyxis without a witness
> -not documenting narcotics in the patient's medical record
> -not documenting patient care in the EMR [electronic medical record]
> -hanging the wrong blood product on a patient
>
> We discussed that since bringing [CR] to dayshift, which she believed would help her improve, Crystal Chaffin continued to monitor and work with [CR] on her medication administration practices and hospital policy for documenting this practice. The problem continued to occur where numerous narcotics over several shifts were removed from the pyxis in doses exceeding the patient's order and without a second nurse to witness. With ongoing coaching and mentoring [CR] was repeatedly making errors that had the potential to become serious safety events so it was felt that we terminate her employment because of her failure to comply these *(sic)* measures that would protect our patients….

(Tr. 2428-2431; R. Exh. 35.)

As an explanation of her performance errors listed above, other records reflect that CR had given a patient a second dose of Dilaudid but did not document it in patient record. This was the second incident of CR improperly medicating patients and not recording it. (Tr. 2439-2440.) When her patient care was reviewed it was noted that 6 of the 14 doses reviewed were not documented on the MAR [medication administration record]. (Tr. 2447-2448; GC Exh. 58.) Ritchie violated the policy on "wasting" narcotics on more than one occasion and CMC was concerned that CR was diverting narcotics, a very serious offense by CMC standards according to Chaffin.[36] (Tr. 2449.)

After CR left CMC Ames was later questioned about why she had not performed a RCA. Ames replied by email stating, "I was told by Kevin [Flint] that the nurse who had hung the wrong blood was no longer employed at CMC and that they just wanted a debriefing instead for the two staff nurses who were upset by this." No further actions were taken until and the RCA was not initiated until it was requested by Dr. Sudilovsky on November 20, 2012. (GC Exh. 36, pg. 4.) The investigation involved various staff personnel, including laboratory staff and eventually a Failure Mode Effect Analysis (FMEA) was conducted.[37] (Tr. 2364, 2612, 2627.)

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[35] The record is silent as to whether RN CR was discharged or resigned.

[36] If more narcotics are removed from the pyxis than are administered to the patient a two nurse process of "wasting" or discarding the unused portions must be documented.

[37] FMEA is one of the tools of conducting a RCA. It sets forth the process as the participants understand it and then looks for where the failures can occur. Then the process rates how severe those failures would be and attempts to develop processes to prevent the more likely possible failures. (Tr. 2632-2633; R. Exh. 40.)

As a result of the 2012 "near miss" incident Newman was re-education but not disciplined because he went in to do the bedside check as was required by the policy at that time and found that CR had already hung, spiked and primed the blood before he arrived. Despite the fact that it was Mead's error that resulted in CR receiving the wrong blood for her patient, and he failed to specifically warn her that there had been some aberration of the normal procedure, Mead was also re-education and received no discipline. Documentation noted that Mead was a new RN and very upset with the mistake. (GC Exh. 53c, pg. 6.) A common theme in the disciplinary documents and incident reports is whether the offending employees were apologetic or remorseful for their mistakes as the documents note that Mead was. This appears to be a valued attribute by CMC and is often cited as a reason to re-educate versus discipline. As part of his re-education, Mead participated in the investigation and the FMEA study concerning the courier's role of trying to handle two requests at the same time. It was from this FMEA review that CMC introduced the 2-tiered, 2-RN policy requiring a thorough check outside the room and a second thorough check inside the room, departing from the accepted practice in the nursing field of a one thorough bedside 2-RN verification.

b. RN discharged for falsification of records after numerous interventions

Kristen Verrill has been the director of the CMC Center for Healthy Living, an outpatient rehabilitation center, at a separate CMC medical campus in Ithaca, New York since 2008. (Tr. 2141-2144.) Verrill discharged RN DN, who worked as an RN for about 9 years before her discharge in 2009. (Tr. 2152-2153; R. Exh. 31(c).) DN assisted and monitored patients performing cardiac rehabilitation. DN was also responsible for monthly checks on the center's cardiac crash cart that holds medications and equipment to treat serious cardiac events. DN was required to verify and document on a detailed checklist that the cart was fully stocked with the required items and that those items were not outdated. (Tr. 2146-2147.) DN was discharged for "continued inability to perform assigned duties and falsification of records related to crash cart documentation." (Tr. 2151; R. Exh. 31a-31c.) A summary of the numerous interactions between management and DN concerning her repeated failure to accurately document the contents of the crash cart on the required checklist verification forms is contained in GC Exh. 48, but DN simultaneously repeatedly made other medical record documentation errors that were brought to her attention on numerous occasions before she was discharged.

On June 15, 2009, Verrill created a memorandum to document her verbal counseling with DN regarding her failure to obtain the necessary documentation for patients to participate in rehabilitation which could jeopardize the facility's certification with the Joint Commission to perform the rehabilitation services. The memorandum also noted DN's failure to properly document patients' participation in rehabilitation services, and Verrill's direction to her that she should not be accruing overtime to perform the documentation when sufficient time was available during her shift. (Tr. 2155-2156, 2158-2159; GC Exh. 47, pg. 1.) Verrill noted in this memorandum that some of these issues had been addressed in DN's last performance review and still had not been corrected. (Tr. 2159.) On June 26, 2009, Verrill documented discussions she had with DN in May 2009 and on June 22, 2009. In May 2009 she had reviewed with DN the "deficiencies" (errors) in the crash cart checklist that she had performed in May that were discovered and reported by another RN so that DN could correct her errors. After DN submitted the checklist verification form for June 2009, a check of the crash cart and then a subsequent recheck verified that she had the same "deficiencies" in the verification checklist that she submitted in May 2009 despite being made specifically aware of those deficiencies. (GC Exh. 47, pg. 2 and 3.)

DN received formal feedback on June 15, 18, 23, and 26, 2009, that she had failed to timely submit patient's attendance records for billing requirements referred to at the facility as "attending" the patient. Verrill discussed these failures to completely document the patients' records with DN on July 2, 2009, and DN again failed to timely submit patients' attendance records on July 2 and 7, 2009, which was

documented and discussed with DN on July 9, 2009. (Tr. 2157; GC Exh. 47, pg. 4.) She again failed to document patients' attendance at rehabilitation on July 14 and 20, 2009, and received a verbal warning documented in writing with regard to these failures to fully document patients' records on July 22, 2009. (Tr. 2157; GC Exh. 47, pg. 5.)

On September 23, 2009, RN DN was suspended pending investigation for failing to properly perform and document the monthly crash cart inventory check list sheets. DN had completed the sheets on July 3 and 31, and September 3, 2009, and the same expired items that where noted on the July 24 recheck of the cart were again found on September 8, 2009, some of which had been expired since 2007. Management had also found 5 pre-completed, but undated copies of the check list identical to the July and September lists submitted by DN except for the date. Verrill also noted that DN's repeated claims that she had corrected the deficiencies could not be accurate because they still existed and were easy to detect.

Verrill repeatedly testified that the reason she discharged DN was solely for falsification of records by making the copies of the checklist with the intent of submitting them without checking the cart. Verrill contended that DN's discipline prior to copying the checklists were "deficiencies" that required performance improvement but that the copying of the checklist was falsification of medical records. (Tr. 2175-2176.) When questioned concerning the meaning of deficiencies Verrill was evasive and unwilling to explain what the term meant in her documentation. Despite DN's obvious failures to record correctly, Verrill described all these earlier inaccuracies in the medical records as innocent errors that simply needed training. I find this testimony implausible when Verrill's records predating the finding of the copied checklists note that such mistakes would be hard to make since these exact mistakes were pointed out to her in May 2009 and Steve Knapp and Sharon Newton reported finding them with minimal effort. See (GC Exh. 47, pgs. 2 and 6.)

Furthermore, Verrill's own discharge notice contradicts her assertion that DN was discharged solely for falsification by copying the checklist. DN's discharge records state:

> My conclusion, based on careful review of your file … after having been given repeated verbal warnings and repeated opportunities to improve, you continued to fail to meet reasonable expectations for satisfactory performance. More seriously, I also concluded that you repeatedly violated established CMC safety practices and falsified CMC safety documents and that those violations were sufficient cause for your immediate discharge.

(R. Exh. 31(b).) I do not credit Verrill's testimony that she only included performance issues in DN's discharge record to put others on notice that she had performance issues as well. (Tr. 2185.) Furthermore, I do not credit Verrill's testimony that she perceived only DN's copying of the checklist as falsification and not her previous refusal to document the checklist accurately. As the discharge document notes, Verrill had warned DN numerous times and she continued to falsify documentation. I also note that Director Kansas Underwood makes similar claims that only the last inconsistent act by the 2 employees she discharged was falsification. I find those claims equally implausible.

c. Discharges of hospital aides

On December 10, 2015, Director Underwood discharged hospital aide JM. JM had numerous disciplines during her short time at CMC including coachings, verbal warnings, written warnings, a shift change, and a 2 day suspension before being discharged for documenting a falsified weight for a congestive heart failure patient. The patient informed the RN that he had not been weighed. The manufactured weight recorded by JM was off by about 10 pounds which would have significantly affected the treatment for the congestive heart failure patient. (Tr. 2222; R. Exh. 32; GC Exh. 49.)

Despite the reference to JM's numerous other disciplines in her discharge record, Underwood insisted that JM "was terminated because she falsified records, and [her other discipline] was included in her termination to paint the picture." In response to a clarifying question Underwood stated, "[The other disciplines] were -- were they considered? No. Were they a part of her story? Yes."(Tr. 2248.) When questioned about the references to these other disciplines in her termination documentation signed by Underwood, she stated that whether they were considered "depends upon your perspective." I find that this testimony strikingly similar to the contention made by Verrill in claiming that RN DN had been discharged solely for the act of falsification despite the discharge documents noting her history of discipline, including a history of not documenting accurately. Again, I find this contention contrived and not credible based upon the discharge records.

On February 16, 2016, hospital aide RS, who was hired on October 5, 2015, was discharge for falsifying a 4-south telemetry unit patients' vital signs. (Tr. 2226; R. Exh. 33.) The VS3 machines used on the telemetry unit to take patient's vital signs electronically record all vital sign readings they take. Multiple RNs complained to Underwood that RS did not enter the vital signs into the patient record as is normally performed. When RNs confronted RS about the missing vital signs, she manually entered them into the record. A review of the VS3 machines electronic record showed that the vital signs that RS entered into the patients' records were not taken by the machines, and therefore, had to be fictitious unless manually taken. (Tr. 2224-2226.) When confronted RS admitted that she made up the vital signs that she recorded. (Tr. 2226.) Underwood testified that if RS had really taken the vital signs manually and recorded it, then Underwood would not have fired her. (Tr. 2259.)

Underwood claims that RS had not received prior discipline, but the counseling form noting her discharge states: "February 15, 2016 Raven falsified blood pressure documentation on multiple patient records. After multiple counseling and coaching by leadership, it is decided to dissolve relationship with [RS] effective immediately." (R. Exh. 33.) Other records, evidence that Underwood extended RS's probation and noted that she "still struggles with the daily tasks of patient care, environmental upkeep, and accurate documentation within her role as health aide." (GC Exh. 50(a).) RS received four other documented coachings for failing to perform tasks as expected. (Tr. 2252; GC Exhibits 50(b) through 50(e).)

d. Discharge of a registered nurse for falsification

The only record evidence of the circumstances surrounding RN MW's discharge is a letter sent on May 12, 2009, in response to MW's appeal of his discharge. The letter details the findings of an investigation into whether MW had performed urinalysis tests for which he had documented test results on patients' medical records. Based upon another employee's statement of what occurred and electronic documentation that MW had not withdrawn the necessary solution for the test from the pyxis dispenser in the relevant time frame, it was concluded that MW had been properly discharged for violating "Section 413 of the Handbook for falsification, because it was found that [he] entered data in the Convenient Care Center Daily Quality Control log on April 4 and 5, 2009, for urinalysis tests without actually having performed the tests." (R. Exh. 30, pg. 1.) The only other information in the record concerning MW is an employment status sheet that notes he was hired on March 1998 as an RN in the Urgent Care-East facility, discharged in April 2009, and is listed as eligible for rehire. (Tr. 3024, 3149-3150; R. Exh. 30, pg. 1.) The record is silent as to whether he had any prior discipline history.

e. Discharge of a registered nurse for medicating a patient against the orders of the treating physician and parental wishes

RN VC was assigned to care for an adolescent in the behavioral health unit. The adolescent requested a medication from VC that the doctor had not ordered and to which the patient's parents had specifically declined. Instead of seeking the authority to administer this medication to the patient, VC took the medication out of the pyxis machine under another patient's name, failed to scan the medication or the adolescent patient's identification bracelet as is required by policy, administered it to the minor and then did not document it in the patient's medical record that the medicine had been administered. Somehow the social worker for the unit became aware that the adolescent had been given the medication and filed an incident report. VC was discharged on June 23, 2016, for this conduct. The discharge notice does not specifically state the reason for discharge but gives a factual explanation of what occurred. Bernice Miller, the interim director of the mental health unit at that time, stated that VC was discharged for administering the medication without a doctor's order and without consent of the patient's parents. (R. Exh. 34; Tr. 2212-2217.) Neither the discharge notice or Miller's testimony address what is readily apparent from the facts of this situation, RN VC intentionally defied the doctor's and parent's orders in administering the medication and attempted to hide this misconduct by not following several procedures that would evidence her actions.

f. Other blood transfusion incident reports

Even if a patient is administered the unit of blood intended for that patient, the patient can still have an unpredictable reaction to the transfusion that can vary from relatively minor increases or decreases in vital signs to serious injury, including death. Dr. Sudilovsky testified that with modern precautions it is these unpredictable reactions that cause the majority of injuries and deaths in transfusions. (Tr. 1850-1852, 1855.) To help prevent these reactions, patients are often given pre-medications such as Benadryl and Tylenol, but a small percentage of patients still have a harmful reaction. The transfusion policy requires RNs to take vital signs before a transfusion is started and again 15 minutes after the transfusion was initiated. The RN should monitor the patient closely during that 15 minute period. Any significant change in vital signs (i.e. blood pressure, heart rate, or temperature) is to be reported to the blood bank for a determination as to how to proceed. The record contains 13 incident reports since 2012 where the administering RN failed to administer the pre-medications or report to the laboratory a significant change in vital signs that could have indicated the onset of a more serious reaction or a possible future serious reaction to subsequent transfusions. In each of these cases it was noted that the reaction or possible reaction did not escalate to the level of causing serious harm and that the RN was re-educated. (GC Exh. 11(h) and (q); GC Exh. 12(a)-(j); 13(b), (e).)

As discussed above the record contains 28 incident reports concerning failures to properly complete transfusion cards. (GC Exh. 11(a)-(bb).) The transfusion cards were returned to the RNs for completion. Only a few of these incident reports note that the RNs involved were question about whether they had actually performed the tasks listed on the card before they initialed and returned the card.

There are numerous incident reports of RNs making medication errors often referred to as the "5 rights"— right medication, right dose, right route, right physician's order, and right patient. (Tr. 2218; GC Exh. 8(a)-(nn).) Based upon the notes in these records, the most serious of these failures involved leaving patients on propofol drips, an anesthesia that requires the patient be on a ventilator due to its effects on respiration, after the ventilator was removed. Documentation notes that CMC management found this situation "is disturbing and will be shared with all staff this week at staff meetings as a safety high alert." (GC Exh. 8n, pg. 3.) This situation was noted as "Severity Level 2—temporary minor harm" as the error was caught by response to telemetry warning alarms. The RN involved was re-educated in a

one-on-one situation in addition to the unit re-training. In another situation where propofol was continued after extubation, the RN received one-on-one re-education and the incident was reviewed in staff meetings. (GC Exh. 8.) Another incident listed as a severity level 2-temporary minor harm was when a patient was suffering from an allergic reaction and the RN, responding to an oral physician order, injected epinephrine into the patient's IV line instead of administering it intramuscularly. Fortunately, another RN was present and immediately clipped the IV line preventing much of the medication from entering the patient's blood stream which could have resulted in a serious change in heart rate. The RN failed to follow the procedure of repeating oral instructions back to the prescribing physician, a failure for which she had been coached before. Under the circumstances, the RN was re-educated. (GC Exh. 8(f).)

Another common error noted in these incident reports is RN's failing to scan a patient's identification bracelet and/or the medication to be given resulting in a violation of one or more of the "5 rights." Failure to use at least two patient identifiers (i.e. name, DOB, or patient identification number) before providing care, the failure to scan the patient identification bracelet and medication before administering medicine, and the failure to label specimens at the bedside in the presence of the patient are considered red rule violations. (GC Exh. 17; GC Exh. 14.) The incident reports show that some of the failures were treated as red rule violations. (GC Exh. 14(a)-(m).) Other similar failures to scan the medication or the patient's identification were not treated as such. (GC Exh. 8(m), (u), (hh), (mm), and (nn); GC Exh. 29.) When a RN or another staff member scans a sticker from a patient's file instead of scanning the patient's actual wrist ban, they are arguably falsifying the record by making it appear that they had identified the patient by actually scanning the patient's bracelet. (GC Exh. 29.) Similarly, when a staff member mislabels a specimen from a patient because they put the label on the specimen outside the presence of the patient and without verifying with the patient or the patient's identification bracelet that they have the correct labels, they are in effect falsifying the medical record to make it appear that they have complied with this policy requirement to do it in the presence of the patient. (GC Exh. 14(k), (l), and (m).)

In each of these incidents, even when the error reached the patient, the RN was re-educated or coached, and in some instances counseled for making a "red rule" violation, but they were never disciplined for falsification by scanning a sticker in the chart instead of the patient's identification bracelet.[38] As discussed above, on September 15, an email circulated amongst management regarding a Hemocue operator red rule violation where the RN repeatedly scanned the identification sticker of another patient from a file/clipboard instead of scanning the identification bracelet on the patient as is required by the Hemocue protocol. When a sticker or identification bracelet is scanned, it is recorded in that patient's record. Because the policy requires that the patient's actual identification bracelet be scanned, the scanning of a sticker instead is falsifying the record to reflect that the patient's identification bracelet was scanned. Even though the email equates this action of scanning the sticker to Marshall and Lamb using the chart to verify the blood, there is no evidence in the record that the employee was ever disciplined for falsifying the record in this manner like Marshall and Lamb were despite the email circulated amongst management equating the two types of conduct. (GC Exh. 31.)

I find CMC's definition of falsification of medical records ambiguous at best. Ames, Raupers, Verrill and Underwood testified that the employee had to intentionally document inaccurately for the conduct to be falsification of medical records, and therefore, the vast majority of mistakes did not constitute falsification. I agree that the record reflects that most errors made by RNs and other staff are simply errors caused by preoccupation, a lack of understanding, or a simple mistake. Yet, RN CR's repeated failure to document the wasting of narcotics, RN DN's repeated unexplainably inaccurate documentation of the crash cart checklist, aide RS's continual failure to take and accurately document vital signs that RNs repeatedly reminded her to do was determined to be falsification only after their managers attempted

[38] The record is unclear if re-education or coaching is documented in employee records but it appears that a counseling is documented.

to re-educate them and then finally labeled their conduct falsification to discharge them. Similarly, the scanning of stickers instead of patient identification wrist bans before treating the patient has not been considered falsification.

D. Analysis of the alleged violations of Section 8(a)(3) and (1) by suspending and discharging Anne Marshall and Loran Lamb

The legal standard for determining whether an employer's action against an employee in violation of Section 8(a)(3) of the Act is set forth in *Wright Line*, 251 NLRB 1083, 1089 (1980), enfd. 662 F.2d 899 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982). To establish a violation of 8(a)(3), General Counsel has the initial burden of showing by a preponderance of the evidence that a substantial or motivating factor in the employer's decision to take the action was the employee's union or other protected activity. *Pro-Spec Painting, Inc.*, 339 NLRB 946, 949 (2003). This burden is typically met by showing the employee engaged in union or protected concerted activity, employer knowledge of that activity, and animus on the part of the employer towards that activity. *Consolidated Bus Transit, Inc.*, 350 NLRB 1064, 1065 (2007), enfd. 577 F.3d 467 (2d Cir. 2009); see also *Medic One, Inc.*, 331 NLRB 464, 475 (2000) (noting that "[e]vidence of suspicious timing, false reasons given in defense, failure to adequately investigate alleged misconduct, departures from past practices, tolerance of behavior for which the employee was allegedly fired, and disparate treatment of the discharged employees all support inferences of animus and discriminatory motivation").

If General Counsel meets this initial burden, then the burden shifts to the employer to prove that it would have taken the same action even in the absence of the employee's union or protected activity. *Adams & Associates, Inc.*, 363 NLRB No. 193, slip op. at 6 (2016); *Libertyville Toyota*, 360 NLRB No. 141, slip op. at 4 (2014); enfd. 801 F.3d 767 (7th Cir. 2015); *Bally's Atlantic City*, 355 NLRB 1319, 1321 (2010) (if General Counsel makes a strong initial showing of discriminatory motivation, the respondent's rebuttal burden is substantial), enfd. 646 F.3d 929 (D.C. Cir. 2011); *Consolidated Bus Transit, Inc.*, 350 NLRB at 1066; *Pro-Spec Painting*, 339 NLRB at 949. The General Counsel may offer proof that the employer's reasons for the personnel decision were false or pretextual. *Pro-Spec Painting*, 339 NLRB at 949 (noting that where an employer's reasons are false, it can be inferred that the real motive is unlawful if the surrounding facts reinforce that inference.) (citation omitted); *Frank Black Mechanical Services, Inc.*, 271 NLRB 1302, 1302 fn. 2 (1984) (noting that "a finding of pretext necessarily means that the reasons advanced by the employer either did not exist or were not in fact relied upon, thereby leaving intact the inference of wrongful motive established by the General Counsel").

If an employer is found to have discriminatorily discharged an employee under *Wright Line,* and the evidence supports that a second employee was discharged for similar reasons "to lend an 'aura of legitimacy'" to the discharge of the first employee, the discharge of the second employee also violates Section 8(a)(3) and (1) of the Act. *Pillsbury Chemical & Oil Co.*, 317 NLRB 261, 261 (1995). This is true regardless of the lack of protected activity or employer knowledge of such activity on the part of the second employee. Id. "Even if [secondary] employees are not direct targets of the employer's discrimination, disciplinary action taken against them is nevertheless unlawful because it is, in effect, 'the fruit of the poisonous tree.'" *FiveCAP, Inc.*, 331 NLRB 1165, 1169 (2000) (citing, *Opryland Hotel*, 323 NLRB 723, 728-729 (1997).

I find General Counsel met its burden under *Wright Line* to prove by a preponderance of the evidence that Marshall engaged in protected union and other concerted activity, that CMC was aware of and harbored significant animosity towards this protected activity and union activity in general. Marshall's actions on the behalf of the Union, including attending union meetings, distribution and posting of union literature, dissemination of union benefit information to fellow employees, and posting information concerning the

ongoing unfair labor practice disputes and other union information on social media cites, clearly constitutes protected union activity. See *Meyers Industries (Meyers I)*, 268 NLRB 493 (1984), remanded sub nom. *Prill v. NLRB,* 755 F.2d 941 (D.C. Cir. 1985), cert. denied 474 U.S. 948 (1985), and *Meyers Industries (Meyers II)*, 281 NLRB 882 (1986), affd. sub nom. *Prill v. NLRB,* 835 F.2d 1481 (D.C. Cir. 1987), cert. denied 487 U.S. 1205 (1988). Her participation in the previous unfair labor practice hearing also constitutes protected concerted activity. The evidence establishes, and Respondent does not dispute, that it was aware of this activity by Marshall.

I further find that CMC harbored significant and unremitting animosity towards Marshall's protected activity. This hostility has been ongoing since CMC engaged in the first discriminatory acts addressed in the earlier decision. CMC continued to view Marshall as the driving force behind the union movement which is evident in CFO Collet's email referring to Marshall as the Union's lead organizer and VP of HR Forrest's email equating the Union's and Marshall's focus or goals as synonymous. CMC felt compelled to defend against Marshall's comments about it as is evident in VP of PR Turner's preparations and constant monitoring of social media posts in order for CMC to dispel any statements made about it by Marshall. As discussed above, CMC values employees who are apologetic for their errors. CMC sees Marshall's support of unionization as a huge error on her part. Her unapologetic stance on these issues has garnered CMC's hostility towards her in general, which, out of necessity, has caused her to be on guard and advocate for herself in meetings with management. This in turn has increased CMC's hostility towards her which is evident in the differences in the tone of voice and manner in which management interacted with Marshall and Lamb in their investigatory and discharge meetings. This is most notable in Raupers' conciliatory statement to Lamb that her colleagues were greatly saddened by her impending discharge and were mad that Raupers could not treat Lamb differently than Marshall. This statement clearly implies that Raupers would have done so if she could; even though, per Dr. Sudilovsky, Lamb's violation of the transfusion policy of not even entering the patient's room to check her identity was more egregious than Marshall's conduct. From the premature drafting of a discharge letter for Marshall but not Lamb, this was about CMC ridding itself of Marshall. These actions along with CMC's ongoing campaign highlighting its perceived detriments of unionization, lead me to find that CMC not only opposed unionization, it harbored substantial animosity towards Marshall's actions in support of unionization.[39]

CMC contends that despite any animosity it had towards Marshall's protected concerted activity, it would have suspended and discharged her and Lamb for failing to perform the 2-RN bedside blood transfusion verification and completing the transfusion card indicating that they had. General Counsel and the Charging Party contend that CMC's reasons for suspending and discharging Marshall and Lamb are pretextual and discriminatory as is evident by the comparable discipline evidence. I find that CMC's asserted reasons for suspending and discharging Marshall, and as collateral damage Lamb, are not supported by the evidence. CMC disparately treated Marshall and by necessity Lamb to support its termination of Marshall.

This incident arose as a patient complaint by patient SF, who was medically and mentally fragile due to her serious illness. Her sister referred to her as being in a dark place caused by the stress of her illness. Marshall stated that in working in ICU that her patients are often in such a state and there is little she can do to do to ease their legitimate concerns. When patient SF questioned Marshall about the 2-RN bedside check Marshall responded in her direct manner. It was this direct manner and lack of a more thorough, response to patient SF's concerns that failed to reassure patient SF, and it was that failure to ease patient SF's fear that angered her sister. I credit Marshall's testimony that she believed she had addressed patient

[39] I make these findings without relying upon the decision in the prior unfair labor practice proceedings. I find the evidence submitted in this hearing alone sufficient to support these conclusions. If the Board affirms the findings in the prior decision, then there would be considerably more evidence to support this finding.

SF's questions because she did not raise the issue with her again, and no family member ever spoke to her concerning the matter.

Raupers, Ames, and Crumb testified about their emotional response to finding that Marshall had not eased patient SF's concerns. Although I do not doubt that CMC's staff attempts to ease patient concerns when they are able, the record contains no evidence that CMC considers patients' reactions to situations in determining the appropriate discipline for its employees. Despite contending that that there was a legal reporting function with regards to the patient complaint and admitting that the incident never approached a reporting requirement as a safety event, CMC decided to handle the matter as serious safety event and hide the outcome of the matter as a patient complaint. Indeed, Respondent actively sought to prevent evidence concerning the patient complaint process from being entered into the record and did not present any evidence of a patient's perspective or complaint as playing a role in the determination of employee discipline. Therefore, as discussed above, I find that the record does not support that CMC would have discharged Marshall or Lamb based upon the patient complaint process. I further find with regard to CMC's contention that Marshall's actions were more egregious because it arose from a patient complaint and/or she failed to placate patient SF's concerns are unsubstantiated and inconsistent with the record as a whole.

Therefore what remains to be determined is whether the evidence supports CMC's contention that it would have discharged a similarly situated employee who had never engaged in protected activity, received no prior disciplines and only excellent performance evaluations, followed the doctor's order, acquired the correct blood for the patient, verified that blood with another RN, verified the patient's identity, administered the blood to the correct patient, and documented on the transfusion card that she had done so. I find that the evidence does not support that claim.

From the outset, this incident was handled differently than other incidents that led to employees being discharged. The comparable discharge evidence shows that typically the unit director and/or manager conducts the investigation and if warranted interacts with Ames or others in the patient safety/quality department and other managerial officials. Ames recalled less than a handful of investigations she had conducted herself, each of which appear to have involved some actual injury. Even in the 2012 "near miss" incident where the wrong blood was spiked, primed, and only a mere release of a clip from being transfused to a patient, Ames did not conduct the investigation. The unit director conducted the investigation and Ames participated in a review of the information and a discussion on how to prevent similar mistakes in the future per her function as the patient safety/quality officer. In this case, Marshall and Lamb were told that the Peer Review Committee determination supported their discharges. No other discipline in the record cites the findings of the peer review committee, and as stated above, the record does not support this committee's findings are typically used in discipline determinations. Indeed, management determined it was inappropriate to reference the committee's findings in their discharge letters.

Management was aware of the incident on the morning of Monday, September 12. Instead of immediately contacting Marshall and Lamb before Marshall left on a planned vacation to ask them to explain the events, CMC set forth on a mission to develop a case against them. CMC contends that its delay in contacting Marshall and Lamb was caused by a regularly scheduled audit and then Marshall's preplanned vacation. Yet, multiple steps were taken in CMC's quest to discharge Marshall during the time the audit occurred, including multiple contacts with patient SF, review of HealthStream coursework, a review of patient SF's blood transfusion history, a review of all blood transfusion incident reports since 2012, a review of transfusion cards, drafts of Marshall's discharge letter, a peer review committee meeting, instructions to ICU charge nurses to remind their RNs to perform a 2-RN bedside check, interviews of other ICU nurses, and the necessary communications amongst management officials

orchestrating these actions. CMC found the time to engage in all of these activities before reaching out to Marshall or Lamb despite these actions being contrary to the just culture/red rules violation investigation procedure that specifically states that review of the policy and others' application of the policy would occur last as such inquiries are known to discourage open communication about an issue. Thus, I do not credit CMC's contention that it was simply too busy with other matters to attempt to get Marshall's and Lamb's input in this matter until September 20.

Indeed, when CMC officials finally met with Lamb on September 21 and Marshall due to her vacation on October 4, it was not to get their side of the story and explore the reasons this occurred but to check off the boxes in its attempt to confirm a "red rule" violation by asking cursory questions that did not allow for them to explain their actions or reveal their misunderstanding of the transfusion card. For example, the only question that was asked of Lamb and Marshall about the transfusion card was whether it contained their initials and signature. Neither of them was asked why they had signed the transfusion card if they had not performed the required bedside checks. These meetings were conducted in this manner despite the September 15 email chain amongst management officials including Ames, Raupers, Crumb, and Sudilovsky discussing this and similar errors as a systemic problem and Ames' interviews with other ICU RNs on September 20 verifying that fact.

As discussed above, I give no credit to Ames' and Raupers' testimony that the investigation had revealed no evidence that other RNs had failed to perform the 2-RN bedside check. Ames' own notes regarding her interviews of the other ICU RNs cannot reasonably be read to be consistent with this claim. These RNs comments to Ames also indicated that the development of this practice arose in ICU due to the extreme demands of the job. Although the red rules disciplinary model seems to only contemplate a particular incident occurring due to isolated conditions such as being short staffed or as a result of constant interruptions, it appears that this systemic practice developed over time due to the RNs struggling to meet ongoing demands, especially during a period of chronic short staffing issues, and limited education on the topic that failed to bring their attention to the issue. When Ames' department attempted to investigate the systemic nature of this problem and provide the additional education warranted by this important safety precaution, Ames concealed the evidence by instructing Anna Bartel, "*Don't do anything yet*." Thus, I cannot credit Ames' and Raupers' testimony that the just culture/red rule violation disciplinary model supported the discharges. To the contrary, the model indicates that the appropriate remedial action was to re-educate Marshall and Lamb, along with the rest of at least the ICU RN staff as Marshall suggested at her discharge meeting.

I find that CMC did determine that it needed to re-educate its staff and did so through directing charge nurses to review the policy and specifically the 2-RN bedside check at staff meetings. In their October 4 meeting, Marshall informed Raupers and Ames that other nurses perform the verification in the same manner and that she was aware that they had told Ames that fact. Ames and Raupers contend that they called special staff meetings that same day to give other RNs the opportunity to tell them what they already knew—other ICU nurses had engaged in the same conduct as Marshall and Lamb. Instead of making a neutral plea for unrestrained responses, they read the patient complaint and emphasizing the need to perform the 2-RN bedside check, before asking for information. Clearly, this was not an honest attempt to gather information under the "no blame/just culture" model. Ultimately, CMC's best re-education tool was the dissemination of the letter informing the staff of the patient's complaint and the RNs' discharges, which also served the purpose of informing the entire staff of what happens if you support unionization. Not only will you be subject to discharge but to public humiliation.

The comparable discharge evidence further supports a finding of CMC's disparate treatment in claiming that Marshall and Lamb intentionally falsified medical records and that such conduct alone warrants discharge. Three of the comparable employees, who were found to have falsified medical records, made

up medical data for their patients (i.e. weight, vital signs, test results) and recorded it in the patients' medical records. The other employee discharged for falsification repeatedly failed to perform the check and submitted a form with wrong data despite several warnings and then made multiple copies of a crash cart medical supply checklist to submit in place of actually doing the checklist. These actions were qualitatively different than Lamb's and Marshall's completion of the transfusion card where they had not made up data, but simply failed to realize that the transfusion card required the data be checked in a certain manner, as did other RNs, including an RN called by Respondent. With the exception of the discharge of RN MW in 2009, for which the record is unclear if he received any prior discipline, all the other discharged individuals were repeatedly reminded by other staff and/or re-educated, coached and/or counseled by management on the same or similar conduct before being discharged.

Lamb's and Marshall's failure to complete the transfusion card correctly is more akin to employees scanning stickers instead of patients' identification bands. The most other employees have received for scanning a sticker, even when it resulted in an error that caused some level of harm, is a documented red rule violation counseling, despite whether they already knew such conduct was not allowed. Scanning the stickers indicates in the medical record that the patient's identification wristband has been scanned to positively identify the patient. Yet, none of these violations were disciplined as falsification of medical records, even after management circulated an email about this practice and noted it was the same conduct.

Furthermore, I do not find that the evidence supports CMC's claim that Marshall's and Lamb's conduct was so egregious to warrant immediate discharge because it involved a failure to follow the blood transfusion policy. In reviewing Board precedent for similar cases, I note that the Board in *Jackson Hospital Corp. d/b/a Kentucky River Medical Center*, 355 NLRB 643, 645 (2010) (enfd. in relevant part by *Jackson Hosp. Corp., v. NLRB*, 647 F.3d 1137 (2011), found for the employer in discharging an RN for her role in administering the wrong blood to a patient, because of the inherent dangers involved in transfusing blood. That patient suffered no injury, because by sheer luck, the blood was compatible with his. The RNs involved claimed to have verified the blood, but this claim was discredited because none of the identifying information (i.e. name, date-of-birth, account number, gender) matched. The Board found that the employer satisfied its burden of proving that it would have discharged the secondary RN for her failure to verify the identifying information, even though there was evidence that the employer had not discharged other RNs who failed to identify and medicate patients correctly. The Board cited the heightened danger in blood transfusions in comparison to improperly medicating patients as a legitimate reason for the employer to have treated the RNs involved in the blood transfusion differently than other RNs who had made errors in medicating patients.

The facts in the instant case are significantly different than those in *Jackson Hospital*. Most strikingly, patient SF was given the correct unit of blood. Furthermore, there is no contention that Marshall and Lamb failed to take any precautions to protect patient SF by totally failing to verify the correct unit of blood for the transfusion. For the reasons discussed above, I credit Marshall's testimony that she individually verified patient SF's identity. Dr. Sudilovsky testified that he could not definitively state that he would have taken the same stance against Marshall if he had known that she individually verified patient SF's identity. Dr. Sudilovsky viewed Lamb's conduct as a more significant violation because she took no action to positively identify the patient. Yet, Marshall had been the focus of management throughout the investigation, and Raupers basically apologized to Lamb for discharging her because she could not be treated differently than Marshall. Moreover, Ames and Raupers took no action to further investigate when 4 ICU nurses, including the charge nurse, clearly informed Ames that the manner in which Marshall and Lamb conducted the blood transfusion verification was not isolated to them. Ames and Raupers had this and other information supporting this conclusion before it suspended or discharged either Lamb or Marshall. If this practice was so inherently dangerous as to require Lamb's and Marshall's suspension and subsequent discharge, then there is no rational explanation for why Ames'

failed to further investigate in a neutral manner the claims by the 4 other ICU nurses that this conduct was not isolate and why she directed her department to not investigate, except that she was intentionally trying to avoid this information for discriminatory reasons.

Furthermore, CMC, with the involvement of Ames and Crumb did not take such a hardline stance in the 2012 "near miss" blood transfusion incident. Then the only RN disciplined/discharged had numerous counselings for failing to "waste" narcotics correctly, which can be interpreted as a falsification of records by omission. Her discharge notice makes it clear that these numerous counselings played a significant role in her discharge. Her failure to follow the transfusion policy by not verifying the unit of blood before hanging, spiking, and priming it, which allowed the wrong unit of blood to become dangerously close to the patient, was not cited as the sole reason for discharge, but the last in a litany of offenses that finally resulted in her discharge. The RN, albeit a new nurse, who placed the wrong unit of blood in the nurse's hand, was simply re-educated.

If a failure to perform the 2-RN bedside check warranted immediate discharge, then why did Ames fail to follow up on the information gave to her by the 4 ICU RNs whom she interviewed, all of which admitted that the 2-RN bedside verification was not always performed by themselves and others. Not only did she fail to investigate those claims more, she prevented others in her department from investigating further or doing more to educate the staff on the proper procedures. These are not the actions of an individual who is motivated by a dire safety concern.

Thus, I find that the record as a whole does not support Respondent's claim that its substantial animus towards Marshall's protected activity was not its motivating factor in discharging Marshall and, to support Marshall's discharge, the discharge of Lamb. By coming to this conclusion, I am not second guessing CMC's claim that a 2-RN bedside check of all of the verification information is the safest method to verify the correct unit of blood will be transfused to the correct patient. I am finding that the evidence does not support that CMC would have suspended and subsequently discharged Marshall and Lamb based upon its discipline model and all the surrounding circumstances, absent its animosity towards Marshall's substantial union and other protected concerted activity. In coming to the conclusion that CMC's suspensions of Lamb and Marshall violated the Act, I note that management had already circulated the September 15 email discussing how this was not an isolated issue and was aware of the 4 ICU nurse's claims that Marshall's and Lamb's conduct was not isolated to them before either Lamb or Marshall were suspended. Therefore, I find that the suspensions were unlawful for the same reasons I found the discharges to be unlawful.

Based upon the totality of the evidence, I find that Respondent failed to satisfy its rebuttal burden of proving that it would have suspended and discharged Marshall, absent her protected activity. I further find that Lamb was suspended and discharged to add legitimacy to Marshall's discharge. Accordingly, I find that Respondent violated Section 8(a)(3) and (1) of the Act by suspending Lamb on about September 21, 2016, suspending Marshall on about October 4, 2016, discharging Lamb on about October 5, 2016, and discharging Marshall on about October 6, 2016.

E. Respondent did not violate Section 8(a)(1) of the Act by failing to inform employees of the safeguards required by *Johnnie's Poultry*

In response to cross-examination questions concerning whether Respondent Counsel had provided RN Nathan Newman with the safeguard warnings required under *Johnnie's Poultry Co.*, 146 NLRB 770 (1964), Newman was unable to fully articulate that he had been informed of all of the safeguards required by *Johnnie's Poultry*. General Counsel orally requested on the record to amend the complaint to include an allegation that Respondent had violated Section 8(a)(1) of the Act by not informing Newman of these

safeguards before questioning him with respect to the complaint allegations. I granted General Counsel's motion to amend the complaint. Respondent denied the allegation on the record. (Tr. 2513-2516.)

In the *Johnnie's Poultry Co.* case, the Board set forth its policy of permitting employers to conduct employee interviews in order to ascertain facts necessary for the preparation of its defense against charges issued. In that case, the following safeguards are set forth:

1. The employer must communicate to the employee the purpose of the questioning.
2. Assure the employee that no reprisals will take place.
3. Obtain employee participation on a voluntary basis.
4. The questioning must occur in a context free from employer hostility to union organization.
5. The questioning must not itself be coercive in nature.
6. The questions must not exceed the necessities of the legitimate purpose by prying into other union matters, eliciting information concerning an employee's subjective state of mind, or otherwise interfering with the statutory rights of the employees.

"When an employer transgresses the boundaries of these safeguards, he loses the benefits of the privilege." *Johnnie's Poultry*, supra at 775.

The brief submitted by General Counsel does not address this allegation. After reviewing the record, the only issue is whether or not the Respondent violated requirement 2 of the *Johnnie's Poultry* safeguards in questioning Newman, which is the contention of the Charging Party. (CP Brief, pg. 53.) Newman testified that Respondent's attorney asked him if he was interested in testifying and he agreed to do it. Newman understood that his participation was voluntary, but he was unable to recall if he was told that there would be no reprisals if he chose not to participate. Newman was unable to recall the specific language used by Respondent's Counsel to convey to him that his participation was "voluntary," but stated that he understood, "I wouldn't be impacted at all. I'm completely doing this on a voluntary basis." (Tr. 2523-2524.) I find that Newman's understanding of the term "voluntary" included an assumption that there would be no reprisals if one failed to volunteer and when he repeatedly testified that he participated in the pretrial interview on a voluntary basis he did so with the understanding that he could decline without repercussions. Furthermore, I find that the other employee witnesses called to testify by Respondent were able to specifically state that were informed of the *Johnnie's Poultry* safeguards when they were interviewed by Respondent Counsel. (Tr. 2761-2763, 2778-2779, 2794-2795, 2912.) I find no reason for Respondent to value Newman's testimony more than other witnesses, and therefore, be motivated to treat him differently.

Based on my findings and conclusions, I find insufficient evidence that the Respondent exceeded the bounds of legitimate pretrial preparation and dismiss the allegation that Respondent violated Section 8(a)(1) by failing to inform employee interviewees of the *Johnnie's Poultry* safeguards.

CONCLUSIONS OF LAW

1. Respondent, Cayuga Medical Center at Ithaca, Inc., in New York, is an employer engaged in commerce out of its Ithaca, New York facility within the meaning of Section 2(2), (6), and (7) of the Act, and a health care institution within the meaning of Section 2(14) of the Act.
2. At all material times, the Union, 1199 SEIU United Healthcare Workers East, has been a labor organization within the meaning of Section 2(5) of the Act.
3. Respondent violated Section 8(a)(1) of the Act, in about July 2017, by removing and/or confiscating union literature from Respondent's bulletin boards.
4. Respondent violated Section 8(a)(3) and (1) of the Act, on about September 21, 2016, by suspending employee Loran Lamb to feign legitimacy for its suspension and discharge of Anne Marshall in retaliation for her union activities.

5. Respondent violated Section 8(a)(3) and (1) of the Act, on about October 4, 2016, by suspending Anne Marshall in retaliation for her union activities.
6. Respondent violated Section 8(a)(3) and (1) of the Act, on about October 5, 2016, by discharging employee Loran Lamb to feign legitimacy for its suspension and discharge of Anne Marshall in retaliation for her union activities.
7. Respondent violated Section 8(a)(3) and (1) of the Act, on about October 6, 2016, by discharging employee Anne Marshall in retaliation for her union activities.
8. Respondent has not violated Section 8(a)(1) of the Act by failing to advise employees, whom it sought to interview in connection with this proceeding, of the *Johnnie's Poultry* safeguards.

REMEDY

Having found that Respondent has engaged in certain unfair labor practices, I find that it must be ordered to cease and desist therefrom and to take certain affirmative action designed to effectuate the policies of the Act.

Respondent, having unlawfully removed/confiscated union literature from its bulletin boards while allowing the posting of other non-Respondent sponsored literature, I recommend that Respondent be ordered to cease and desist from removing/confiscating union literature from its bulletin boards.

Respondent, having unlawfully suspended and subsequently discharged Anne Marshall and Loran Lamb, I recommend an order requiring Respondent to offer Anne Marshall and Loran Lamb full reinstatement to their former jobs or, if their jobs no longer exist, to substantially equivalent positions, without prejudice to their seniority or any other rights or privileges previously enjoyed, to make them whole for any loss of earnings and other benefits suffered as a result of the discrimination against them. Backpay shall be computed in accordance with *F. W. Woolworth Co.*, 90 NLRB 289 (1950), with interest at the rate prescribed in *New Horizons*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB 6 (2010). In accordance with the recent decision in *King Soopers, Inc.*, 364 NLRB No. 93 (2016), Respondent shall compensate Anne Marshall and Loran Lamb for their search-for-work and interim employment expenses regardless of whether those expenses exceed interim earnings. Search-for-work and interim employment expenses shall be calculated separately from taxable net backpay, with interest at the rate prescribed in *New Horizons*, supra, compounded daily as prescribed in *Kentucky River Medical Center*, supra.

Additionally, I recommend that Respondent be ordered to compensate Anne Marshall and Loran Lamb, for the adverse tax consequences, if any, of receiving a lump-sum backpay award, and to file with the Regional Director for Region 3, within 21 days of the date the amount of backpay is fixed, either by agreement or Board order, a report allocating the backpay award to the appropriate calendar years. *AdvoServ of New Jersey, Inc.*, 363 NLRB No. 143 (2016).[40] Finally, Respondent shall be ordered to remove from its files any reference that it suspended and discharged Anne Marshall and Loran Lamb, and to notify them in writing that this has been done and that these adverse actions will not be used against them in any way.

Respondent having been found to have engaged violations of the Act, I recommend that Respondent be ordered to post at its facility in Ithaca, New York, copies of the attached notice marked "Appendix." Copies of the notice, on forms provided by the Regional Director for Region 3, after being signed by the Respondent's authorized representative, shall be posted by the Respondent and maintained for 60

[40] The General Counsel argues Marshall and Lamb are entitled to consequential damages. I cannot order Respondent to pay consequential damages for costs Marshall and Lamb may have incurred as a result of Respondent's unfair labor practices. As the Board has recognized, current law does not authorize me to award consequential damages. See, e.g., *Guy Brewer 43 Inc.*, 363 NLRB No. 173, slip op. at 2 fn. 2 (2016).

consecutive days in conspicuous places, including all places where notices to employees are customarily posted. In addition to physical posting of paper notices, notices in each language deemed appropriate shall be distributed electronically, such as by email, posting on an intranet or an internet site, and/or other electronic means, if the Respondent customarily communicates with its employees by such means. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. If the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice in each appropriate language to all current employees and former employees employed by the Respondent at any time since July 1, 2016.

Respondent having unlawfully suspended and discharged Anne Marshall, the lead union organizer, and another employee in order to legitimatize its discharge of Marshall, and publicly announced this to all of its staff, volunteers, and physicians through an emailed letter and through high management officials attending staff meetings to read the patient complaint and discussed the matter with employees, I recommend Respondent be ordered to hold a meeting or meetings during working hours, which shall be scheduled to ensure the widest possible attendance, at which the attached notice marked "Appendix" is to be read to employees by a responsible management official in the presence of a Board agent and an agent of the Union if the Region or the Union so desires, or, at the Respondent's option, by a Board agent in the presence of a responsible management official and, if the Union so desires, of an agent of the Union. General Counsel requested that the remedy require a reading of the notice aloud to all CMC staff by a high-ranking management official in the presence of a Board agent or by a Board agent in the presence of a high-ranking management official. I find that the circumstances of this case warrant such a remedy. Respondent unlawfully suspended and discharged Marshall, the lead union organizer, who Respondent had just recently defended other unfair labor practices against her which were later found by the Board to have been unlawfully motivated because of her union and other protected concerted activity. Respondent also discharged Lamb because she happened to be the employee who was working with Marshall when Marshall's mistake in performing her duties was reported. Respondent then announced the discharges of Marshall and Lamb in an unprecedented manner by emailing a letter concerning the matter to all CMC staff, volunteers, and physicians. Furthermore, high management officials attended shift meetings, read the patient complaint and discussed the policy involved and the discharges of Marshall and Lamb. The Board has ordered the reading of the notice in cases where the lead union organizer has been discharged and that fact is widely disseminated to other employees. See *Bozzutos, Inc.*, 365 NLRB No. 146, slip op. at 1 (2016), and cases cited therein.

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended.[41]

ORDER

Respondent, Cayuga Medical Center at Ithaca, Inc., in New York, its officers, agents, successors, and assigns, shall

1. Cease and desist from

(a) Removing and/or confiscating posted union literature from bulletin boards.

[41] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

(b) Disciplining, suspending, or discharging employees because of their union or protected concerted activity.

(c) Disciplining, suspending, or discharging employees because of the union or protected concerted activity of other employees or to feign legitimacy for the unlawful discipline, suspension or discharge of other employees.

(d) In any like or related manner interfere with, restrain, or coerce you in the exercise of the rights listed above.

2. Take the following affirmative action necessary to effectuate the policies of the Act.

(a) Within 14 days from the date of this Order, offer Anne Marshall and Loran Lamb reinstatement to their former jobs, remove from their files all references to the unlawful suspensions and discharges of Anne Marshall and Loran Lamb and notify them in writing that this has been done, and that none of these adverse actions will be used against them in any way.

(b) Make Anne Marshall and Loran Lamb whole for any loss of earnings and other benefits suffered as a result of their unlawful suspensions and discharges, less any net interim earnings, plus interest, plus reasonable search-for-work and interim employment expenses.

(c) Compensate Anne Marshall and Loran Lamb for the adverse tax consequences, if any, of receiving a lump sum backpay award, and file with the Regional Director for Region 3, within 21 days of the date the amount of backpay is fixed, either by agreement or Board order, a report allocating the backpay award to the appropriate calendar year.

(d) Preserve and, within 14 days of a request, or such additional time as the Regional Director may allow for good cause shown, provide at a reasonable place designated by the Board or its agents, all payroll records, social security payment records, timecards, personnel records and reports, and all other records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of backpay due under the terms of this Order.

(e) Within 14 days after service by the Region, post at its facility in Ithaca, New York, copies of the attached notice marked "Appendix" copies of the notice, on forms provided by the Regional Director for Region 3, after being signed by the Respondent's authorized representative, shall be posted[42] by the Respondent and maintained for 60 consecutive days in conspicuous places, including all places where notices to employees are customarily posted. In addition to physical posting of paper notices, notices in each language deemed appropriate shall be distributed electronically, such as by email, posting on an intranet or an internet site, and/or other electronic means, since the Respondent customarily communicates with its employees by such means. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. If the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice in each appropriate language to all current employees and former employees employed by the Respondent at any time since July 1, 2016.

(f) Within 14 days after service by the Region, hold a meeting or meetings during working hours, which shall be scheduled to ensure the widest possible attendance, at which the attached notice marked "Appendix" is to be read to employees by a responsible management official in the presence of a Board

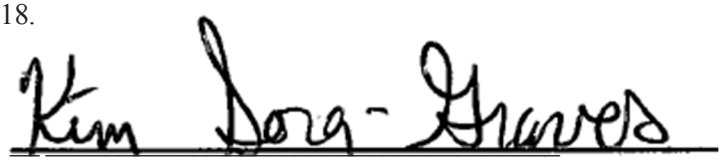
[42] If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

agent and an agent of the Union if the Region or the Union so desires, or, at the Respondent's option, by a Board agent in the presence of a responsible management official and, if the Union so desires, of an agent of the Union.

(g) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

IT IS FURTHER ORDERED that the complaint is dismissed insofar as it alleges violations of Section 8(a)(1) of the Act with regard to failure to inform employees of the safeguards set forth in *Johnnie's Poultry* or other allegations not specifically found herein.

Dated: Washington, D.C. January 8, 2018.



KIMBERLY R. SORG-GRAVES
ADMINISTRATIVE LAW JUDGE

APPENDIX

NOTICE TO EMPLOYEES
POSTED BY ORDER OF THE
NATIONAL LABOR RELATIONS BOARD
AN AGENCY OF THE UNITED STATES GOVERNMENT
FEDERAL LAW GIVES YOU THE RIGHT TO:

- Form, join, or assist a union;
- Choose a representative to bargain with us on your behalf;
- Act together with other employees for your benefit and protection;
- Choose not to engage in any of these protected activities.

WE WILL NOT do anything to prevent you from exercising the above rights.

WE WILL NOT remove and/or confiscate posted union literature from bulletin boards.

WE WILL NOT discipline, suspend or discharge you because of your union activity.

WE WILL NOT discipline, suspend or discharge you because of the union activity of your coworkers, or to feign legitimacy for our unlawful discipline, suspension or discharge of your coworkers.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights listed above.

WE WILL offer Anne Marshall and Loran Lamb full reinstatement to their former jobs or, if those jobs no longer exist, to a substantially equivalent positions, without prejudice to their seniority or any other rights or privileges previously enjoyed.

WE WILL make Anne Marshall and Loran Lamb whole for any loss of earnings and other benefits suffered as a result of our discrimination against them, in the manner set forth in the remedy section of the decision.

WE WILL compensate Anne Marshall and Loran Lamb for the adverse tax consequences, if any, of receiving a lump sum backpay award, and WE WILL file a report with the Social Security Administration allocating the backpay award to the appropriate calendar quarters.

WE WILL remove from our files any reference to our unlawful suspensions and discharges of Anne Marshall and Loran Lamb, and we will notify each of them in writing that this has been done and that their suspensions and discharges will not be used against them in any way.

CAYUGA MEDICAL CENTER AT ITHACA, INC.,

(Employer)

Dated _____ By _____

(Representative) (Title)

The National Labor Relations Board is an independent Federal agency created in 1935 to enforce the National Labor Relations Act. It conducts secret-ballot elections to determine whether employees want union representation and it investigates and remedies unfair labor practices by employers and unions. To find out more about your rights under the Act and how to file a charge or election petition, you may speak confidentially to any agent with the Board's Regional Office set forth below. You may also obtain information from the Board's website: www.nlrb.gov.

Niagara Center Building., 130 S. Elmwood Avenue, Suite 630, Buffalo, NY 14202-2465
(716) 551-4931, Hours: 8:30 a.m. to 5 p.m.

The Administrative Law Judge's decision can be found at www.nlrb.gov/case/03-CA-185233 or by using the QR code below. Alternatively, you can obtain a copy of the decision from the Executive Secretary, National Labor Relations Board, 1015 Half Street, S.E., Washington, D.C. 20570, or by calling (202) 273-1940.

THIS IS AN OFFICIAL NOTICE AND MUST NOT BE DEFACED BY ANYONE

THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER, (518) 419-6669.